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ABSTRACT

This volume presents 13 papers focusing on definition and assessment, interventions, comprehensive systems for services, and teacher training issues related to students with emotional and behavioral disorders. Papers include: "The State of the Art in Behavioral Disorders: Changing Problems, Populations, and Paradigms--Keynote Paper" (Eleanor C. Guetzloe); "Screening Children in Head Start for Emotional or Behavioral Disorders" (Steven R. Forness and David Finn); "The Social Maladjustment Issue Revisited: How Confident Are School Psychologists and Special Education Teachers in the Decision-Making Process?" (Stephanie Stein and Kenneth W. Merrell); "The Effects of Music on the Classroom Behavior of Behaviorally Disordered Youth" (Thomas McIntyre and others); "Promoting Social Skills Training in General Education Classrooms: Issues and Tactics for Collaborative Consultation" (John W. Maag); "Implementing Self-Monitoring Interventions in the Classroom: Lessons from Research" (Robert Reid); "Guidelines for the Successful Reintegration of Students with Emotional and Behavioral Disorders" (Kevin J. Callahan and others); "Postsecondary Employment Outcomes: Suggestions for Developing a Follow-Along Study" (Karen L. Barnes); "Re-ED and Hobbs' Twelve Principles: Twenty-Five Years Later" (Robert A. Gable and others); "Interagency Community-Based Services for Children and Youth with Emotional and Behavioral Disabilities--Keynote Paper" (Cheryll A. Pearson and C. Michael Nelson); "Designing a Comprehensive System of Services for Indiana: Project CONNECT, Phase 1" (Lewis Polsgrove and others); "Stress among General and Special Education Teachers of Students with Emotional or Behavioral Disorders: Possible Implications for Full Inclusion" (Dwight P. Sweeney and Arthur J. Townley); and "Collaboration: Self-Perceived Knowledge, Skills, and Activities of Rural Special Educators of Students with Behavioral Disorders" (Regina M. Foley and others). (References accompany each paper.) (JDD)

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MONOGRAPH

In Behavioral Disorders



Severe Behavior Disorders of Children and Youth

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The Council for Children with Behavioral Disorders is a national professional organization for those interested in the education and well-being of individuals with emotional/behavioral disorders. The Council functions to develop lines of communication and interaction among professionals, disciplines, and organizations; to promote adequate programs for recruitment, training, and consultation; to encourage research and development; and to support legislation for services to these children. Toward this end, the Council publishes a quarterly journal, *Behavioral Disorders*, and sponsors national conferences in relation to these interests. An organization of some 9,200 members, the Council maintains central offices at 1920 Association Drive, Reston, Virginia 22091.

Monographs in Behavioral Disorders is a special publication issued by the Council for Children with Behavioral Disorders to augment the organization's quarterly journal, *Behavioral Disorders*. The *Monograph* is designed to treat topics in an intensive, highly-focused manner not usually appropriate for standard journal presentation.

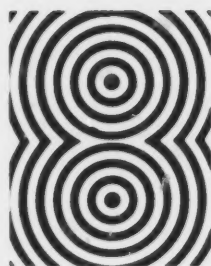
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MONOGRAPH in Behavioral Disorders



Severe Behavior Disorders of Children and Youth

**Robert B. Rutherford, Jr.
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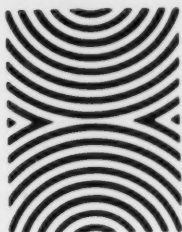
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Preface

Volume 16 is the latest issue of the *Monograph in Behavioral Disorders: Severe Behavior Disorders of Children and Youth* series. This volume includes thirteen selected papers originally presented at the 16th annual Teacher Educators for Children for Behavioral Disorders conference held in Tempe, Arizona in November 1992. These papers focus upon definition/assessment, interventions, comprehensive systems for services, and teacher training issues related to students with emotional and behavioral disorders.

The Editors thank the Executive Committee of the Council for Children with Behavioral Disorders for their continued support of this Monograph series. In addition, we express our sincere appreciation to the Consulting Editors of *Behavioral Disorders* for their thoughtful reviews and to Anne Rhodes for the technical expertise that contributed to the successful completion of this volume.

Robert B. Rutherford, Jr.
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The State of the Art in Behavioral Disorders: Changing Problems, Populations, and Paradigms

Eleanor C. Guetzloe

In this period of rapid social and political change, considerable professional attention has been focused on the special plight of children and youth with emotional/behavioral problems. Authorities have presented varying views related to such issues as the regular education initiative (REI) and inclusion, school restructuring and reform, meeting the needs of changing populations, and the ever-shifting "scientific paradigms." Professional dialogue has reflected such factors as (a) the dissatisfaction of some public officials (and some educators) with the outcomes of special education programs, and (b) the perceptions of some that special education professionals are reluctant to respond to the changing times. Some of this criticism is deserved, but much of it is not. This discussion will focus on (a) our changing problems and populations in the field, (b) the "paradigmatic" arguments, and (c) our present movement in special education (particularly within the Council for Children with Behavioral Disorders) toward a concerted proactive response to the needs of children and youth with emotional/behavioral disorders.

Our Changing Problems and Populations

In the last several decades, many authorities have commented upon the failure of our traditional social institutions — family, school, church, community, government, and even entire nations. There is considerable evidence that "traditional" family problems are now exacerbated by such factors as substance abuse, poverty, unemployment, homelessness, marital violence, physical and sexual abuse, mental illness, mobility, availability of weapons, single parent families, unmarried couples living together, acceptance of out-of-wedlock pregnancies, and teenagers (even children) having babies.

Many children in the United States have either no family or no home. Indeed, figures show that approximately 500,000 youngsters now live without parents in detention centers, hospitals, foster homes, and mental health centers. On any given night, at least 100,000 are homeless (Davis & McCaul, 1990). If the present trend continues, the number will approximate 840,000 by 1995 ("No Place to Call," 1989).

Authorities also report an increase in the prevalence of emotional/behavioral disorders. According to James Leckman, at least 12% of America's children under the age of 18 are mentally ill. Dr. Leckman noted that this is a conservative estimate; the actual rate may be as high as 22% of that age group, or about 14 million children. His report, which was circulated by Associated Press in December of 1989, further suggested that (a) only 20-33% of children with mental illness receive medical assistance for their disorders, and (b) that medical professionals generally identify only about 25% of their young patients with mental disorders. In a federally-sponsored national survey of the parents of 17,000 children, it was reported that only 25% of the children with emotional/behavioral problems received any kind of special education help in school ("Problems Found," 1990).

In the field of education, there are other unsettling occurrences. The momentum of school reform and school restructuring, the exact nature of which remains somewhat unclear, has nevertheless been sustained for over 10 years. The economic recession has taken its toll on schools as well. Classes are overcrowded, instructional materials are in short supply, and furthermore, teacher salaries have not kept pace with the cost of living. There is a critical shortage of educators in some subject areas (e. g., special education) which has resulted in the use of untrained and unskilled teachers in the classroom, especially in programs for children with emotional/behavioral disorders.

At the same time, there is an epidemic of violence among the young that is unparalleled in history. Young people kill for drugs, for initiation into gangs, for love, for hate, and

for no apparent reason at all. Experts lay the blame on three familiar factors: (a) drugs, (b) easy access to handguns, and (c) the rise of violent youth gangs. The schools, the last bastions of safety, are now also becoming battlegrounds. During the 1986-1987 school year, there were 61,000 aggravated assaults (25,000 with injuries), 44,000 robberies (8,700 with injuries), and more than 300,000 simple assaults (80,900) in the schools. Weapons were used in more than 70,000 of these violent crimes: knives in more than 20,000 incidents and guns in more than 1,700 (Weitzel, 1988). The incidence of school violence continues to escalate rather than abate. Current reports abound of students with guns holding classrooms hostage; of students assaulting and killing teachers, administrators, and fellow students; and of students killing themselves. In short, the climate in many schools is often one of violence and fear.

An obvious question arises: Is it any wonder that teachers of children with emotional/behavioral disorders report that their students exhibit signs of more severe problems than they have ever seen before? Among the new populations with whom our teachers are working are children born with Acquired Immune Deficiency Syndrome (AIDS), children born addicted or prenatally exposed to drugs, homeless children, children who survived after being abandoned to die, and children who have already killed another human being, all of whom exhibit serious behavioral disorders. Among children with disabilities, those with emotional/behavioral disorders are, among all children with disabilities, the least welcome in the regular school program. These new populations will be even less likely candidates for successful integration with their normal peers, yet there are those who persist in the movement toward total integration for all children with disabilities, one of the "newer" educational paradigms. This confrontation of educational options promises to challenge us well into the next century. A difficult but important task for educators in the field of behavioral disorders will be to serve as advocates for their student population while also supporting the continuance of multiple service delivery options. Not every student with an emotional/behavioral disorder can achieve success in the regular school program!

The Ever-Shifting Paradigms

Paradigm, one of the most overused terms of this decade, is defined as "a pattern, example, or model" (McKechnie, 1963, p. 1298). A paradigm does not have to be a worldview; it could be considerably smaller in scope. There are a great number of paradigms or models that have proved useful in education such as the fundamental factors important in human learning (drive, cue, response, and reinforcement) as proposed by Dollard and Miller (1950). Another paradigm that still has "goodness of fit" is that of social learning (Bandura, 1973), as many authorities point to modeling in the media, as well as in society-at-large, as the most critical causal factor in the epidemic of violence that afflicts our country.

Over the last several years, there has been considerable rumination about paradigms by a number of educators, some of whom claim special education as their field of endeavor, in language that a practitioner does not normally use in conversations about school restructuring. Some of these individuals seem to be devoutly antibehavioral despite evidence of the effectiveness of behavioral approaches. Some criticize the present organization of the school and argue for restructuring but give very little direction for improvement. Some suggest that all children with disabilities should be placed in regular education regardless of the severity of the disabling condition. There is little agreement regarding a favored position or even the meaning of paradigm. All, however, argue for change and seem to think that anything traditional is inappropriate. They have not yet described a better system, school, or classroom. It is time for them to explain — in words of only two or three syllables — their visions of what special education should be rather than continuing to dwell on the obstinance of the unenlightened, atomistic, mechanistic defenders of the prevailing paradigms. Professionals in special education are eager to have these proposed paradigms translated into better educational practices, examples of which have not yet been made available.

In our area of special education, we are always hungry for greater understanding of the nature and needs of the students with whom we work, as well as ways in which we can help them to become all that they can be. Those of us who are engaged in teacher education continue to read, learn, and attempt to interpret new patterns of thought so that our students can benefit from the latest thinking related to their mission. If there are better models, new ways to translate divergent theories into effective education and treatment for students with emotional and behavioral disorders, then those should be incorporated in our school programs.

Old paradigms that fit. An old concept that comes to mind is that of "anomie," a societal condition characterized by a sense of normlessness or absence of accepted standards, which stems from rapid social change (Merton, 1957). If there is a need for massive restructuring in our field because of the changing nature of our populations and society itself, it may be that the changes should be in the direction of more structure rather than less, and toward tradition rather than away from it. Not all historical practices were ineffective or inhumane.

In the field of knowledge-sharing, there is at least one real benefit in growing old. If you live long enough, you will have the opportunity to realize that we have walked this path before. For example, "putting the child at the center of the educational program" has been practiced in our field of special education for at least the 25 years to which I can personally attest. We have clearly understood the desirability of building on a student's strengths before attempting to correct deficits. No thinking person would argue for teaching skills in isolation rather than relating them to real experience. I am comforted by the knowledge that the "whole language" approach to reading is the same method that I used in the early 50s when I was a "normal" classroom teacher. Further, "full inclusion" was in place when I began my career in ordinary (as opposed to special) education, primarily because there were very few special services for children with disabilities. Another example is the rediscovery, every 10 years or so, of the value of outdoor education for children with emotional/behavioral problems. In 1965, The Hogg Foundation for Mental Health published *Wilderness Road* (Loughmiller, 1965) which described Camp Woodland Springs, a year-round camp for emotionally disturbed boys which had been in operation since the mid-1940s. The Fresh Air Camp at the University of Michigan, directed by William Morse and David Wineman, was in place in the early 50s (Long, 1989).

There are several other models that have stood the test of time such as the public health model of prevention (Caplan, 1964), the principles of Project Re-Ed (Hobbs, 1966), the concepts of life space intervention (Redl, 1959; Wood & Long, 1991), and Hewett's Learning Triangle (Hewett, 1968; Hewett & Taylor, 1980). We can look at these old models from new perspectives; all of these and many others have utility in a variety of settings as well as over time. Levels of prevention and intervention; creating support systems across environments; and appropriate tasks, conditions, and consequences must be carefully considered in the home, workplace, and community.

The first step forward. According to John Johnson, one of the founders of the Council for Children with Behavioral Disorders, there is an old African proverb, "The first step forward is a step backward to tradition" (personal communication, 1991). It is time for us to begin our own "back-to-basics" movement, taking a step backward to our own traditions. We have considerable knowledge of "things that work" and paradigms that fit, and we must not abandon them. We have time-honored traditions of meeting children's basic needs; working with parents, community agencies, and treatment providers; providing a full continuum of educational placements; providing a safe and positive school environment; modifying curriculum to meet individual needs; providing appropriate structure and rewards; teaching academic and social skills; documenting results; and sharing information with our colleagues. We cannot claim to be doing everything right with every child in every setting, but within our number we have the knowledge and skills necessary to provide appropriate programs for the children for whom we accept responsibility. Our restructuring movement should be in the direction of remembering, recalling, reviewing, refining, renegotiating, repossessing, and rebuilding our programs. We need a "special education initiative!"

Our Proactive Response

Within the past several years, The Council for Exceptional Children (CEC) and the Council for Children with Behavioral Disorders (CCBD) have embarked upon an expanded program of interagency communication and collaboration. We have worked with other institutions and organizations (e.g., the Office of Special Education and Rehabilitative Services [OSERS], the National Special Education and Mental Health Coalition, the Federation of Families for Children's Mental Health, and the National Juvenile Justice Coalition) to advocate for children and youth with emotional problems, their families, and the professionals who work with them. OSERS has responded to the needs in the field by supporting a number of new initiatives targeted for children with serious emotional disturbance and their families. These projects have included two Electronic Town Meetings, a research project dedicated to analysis of the knowledge base, and 11 projects with the mission of designing and implementing a comprehensive system of interagency collaboration.

CCBD has worked extensively with others toward establishing a national agenda for children with serious emotional disturbance and their families. In a remarkable exhibition of collaboration, the member organizations of the National Mental Health and Special Education Coalition have agreed upon the terminology (emotional/behavioral disorders) to be used in a proposed change in the federal definition. This will be a concerted response to the common question, "Are we serving the right children?"

Now that we are cooperating within our own house, we must work more closely with professionals in the other disciplines that are concerned with emotional/behavioral disorders. We need to learn about their best practices and share ours. Many useful research findings regarding both education and treatment of our students have come from other fields of inquiry.

This discourse is not, however, a call for total agreement. Another of our long-standing CCBD traditions is the provision of a forum for professional dissent. We have a rich history of questioning prevailing theories, concepts, and schools of thought. We must, however, honor one another's efforts to search for answers. Several years ago at an international symposium in Minneapolis, Nicholas Long wondered aloud about the young colleagues who were in attendance:

Were they aware of how unique this field is, and what a close-knit professional family we are? Were they aware that this is the only professional organization in special education in which the founding fathers and their followers never split into rival warring camps, motivated to depreciate each other? Were they aware that our professional relationships also reflect life-long friendships based on mutual respect and appreciation of our contributions to the field? And were they aware of our binding belief in the importance of self-understanding, accepting differences in others, advocating and caring for resistant students, and learning teachable concepts and skills? (Long, 1989, p. 45)

His points are well taken. His words could become our creed.

Continuing Need for Research

Finally, there is a continuing need for reliable information regarding interventions that are effective, that result in real changes in behavior. We are interested in qualitative changes as well as those that can be counted, timed, or preserved as permanent products. Educators, mental health practitioners, and others who serve children and youth with emotional/behavioral disorders should carefully document the effects of the various interventions employed in the classroom and in other settings. We do have some success stories and we need to make those public. Those of us who know about "things that work" have a responsibility to share those findings.

After a recent conference workshop, a participant came forward and made the following comment: "What you have done is to bring together so many important things — things that I know or once knew and had forgotten. As you said, there really isn't much that's new but we do need to put it all together. I'm going home and do just that."

In summary, I believe that this is what we all must do. I am convinced that we need to look to history as well as the present for guidance — learning and relearning the best that this field has to offer. Our children will benefit from our efforts.

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Screening Children in Head Start for Emotional or Behavioral Disorders

Steven R. Friedman and David Finn

ABSTRACT

Review of selected studies of schoolage children and adolescents with emotional or behavioral disorders suggests that this diagnostic category is highly associated with several environmental risk factors characteristic of children served in Head Start. Relatively little attention has been paid, however, to early identification of emotional or behavioral disorders in Head Start programs. Of 67,958 Head Start children identified as eligible for special education, only 4.6% were categorized as having emotional or behavioral disorders. Procedures for screening preschool children with emotional or behavioral disorders and recent developments in this area are presented and discussed.

Those concerned with the underidentification of children with emotional or behavioral disorders (EBD) in school settings invariably suggest that lack of systematic early identification is at least partially responsible for so few children being found in this category of special education (Beare & Lynch, 1986; Center & Obringer, 1987; Forness & Kavale, 1989). With the emphasis on early intervention in the early childhood amendments of Public Law 99-457, it seems clear that preschool screening for emotional or behavioral disorders will take on increasingly greater importance. The purpose of this article is to make a special case for Head Start as a particular venue for preschool screening of children with emotional or behavioral disorders, to assess the current state of identification of such children in Head Start programs, and to discuss selected recent developments in this area that may serve to clarify the procedures appropriate to screening children for emotional or behavioral disorders in Head Start.

Head Start is a preschool program that has as its primary mandate the delivery of services to 3- and 4-year-old children from low income families (Zigler & Muenchow, 1992). These services are expected to be family based and coordinated with other agencies. Head Start also is expected to integrate children with disabilities into its programs such that no fewer than 10% of its population are children with disabilities (U.S. Department of Health and Human Services, 1991). This integration policy, furthermore, emphasizes mainstream services to children with disabilities.

The Case for Head Start in Screening for Emotional or Behavioral Disorders

Although the association of poverty and disability has been made before, this association has focused primarily on cognitive disabilities such as mental retardation and learning disabilities (Barnett & Escobar, 1990; Baumeister, Kupstas, & Klindworth, 1990; Guralnick & Bennett, 1987; Hallahan, 1992; S. Ramey & C. Ramey, 1992). Less emphasis has been given to the association between environmental risk factors associated with low income and emotional or behavioral disorders. However, considerable evidence suggests that this association too can be made. Studies of schoolage children with emotional or behavioral disorders are beginning to report subject identification criteria that go beyond the traditional diagnostic and instrumentation procedures specific to this particular population (Kavale, Forness, & Alper, 1986). There is now much more emphasis than before on reporting associated factors or variables such as (a) socioeconomic status, (b) single parent families, (c) low parent educational attainment, (d) parent arrest record, (e) parent history of substance abuse or psychiatric disorders, and (f) abuse or neglect of subjects.

Selected examples of this more recent literature, across different types of studies, suggest that these six risk factors are likely to be elevated in samples of children with emotional or behavioral disorders. Ramsey and Walker (1988), for example, have been conducting a longitudinal follow-up of 39 elementary schoolboys with antisocial behavior in Eugene, Oregon. In their sample, 46% of the families involved had income less than

\$10,000, and another 26% had income between \$10,000 and \$20,000; 39% of families were headed by either a single or foster parent, and 34% of parents had a record of one or more criminal arrests. In an ongoing study of 109 children identified for EBD programs in the Gettysburg, Pennsylvania area, Mattison and his colleagues (Mattison et al., 1986; Mattison, Morales, & Bauer, 1992) found that 61% came from single parent families, more than 60% of the parents had not completed high school, and over 80% of the parents had a psychiatric disorder. Some 56% of the children had suffered serious abuse or neglect.

Silver and her colleagues (Silver et al., 1992) have been conducting a longitudinal study of 722 children who were identified as EBD in either public mental health or special education systems. These subjects initially were identified across six different states. More than 60% of families were in the lowest two of the seven socioeconomic status levels used. Almost 54% of children were not living with one or both parents, only 21% of their biological parents were still married, and 58% of their parents had never obtained a high school diploma. More than 30% of parents had either mental illness or a substance abuse disorder and 23.5% had a criminal record. Some 67% of children had experienced abuse or neglect. Percentages of the six factors mentioned above were also quite similar in other nonschool-based studies of 192 children receiving mental health services in San Francisco (Barber, Rosenblatt, Harris, & Attkisson, 1992), and in one of the two major longitudinal epidemiologic studies ($N = 881$) of child psychiatric disorders currently ongoing anywhere in North America (Offord et al., 1992).

To summarize these data, it is clear that several factors associated with low income families are quite common in representative EBD populations. Though some of these factors are not exclusively characteristic of low income families (e.g., abuse or neglect), these factors generally tend to cluster together in disadvantaged or at-risk populations (S. Ramey & C. Ramey, 1992). Also pertinent to this discussion are a variety of newly recognized disorders now affecting the size and scope of the problem of at-risk populations (Baumeister et al., 1990; Guralnick, 1991; Zigler & Freedman, 1987). As indicated above, some of these disorders have significant *behavioral* sequelae above and beyond the cognitive problems that have been the traditional source of concern in at-risk populations (Bauer, 1991; Santos, 1992; Streissguth et al., 1991). Finally, the scope of these and related disorders is such that relatively comprehensive family services are seen as vital to the success of any early intervention efforts with at-risk children (Bailey, Buysse, Edmondson, & Smith, 1992; Colarusso & Kana, 1991; Guralnick, 1989; Mahoney & O'Sullivan, 1990; National Association of State Boards of Education, 1988; Nelson & Pearson, 1991).

That Head Start has as its mandate the provision of comprehensive services to preschool youngsters from low income families would thus seem to make it an ideal venue for early identification of children with emotional or behavioral disorders. Relatively few studies have focused, however, on behavioral or emotional disorders of preschool populations generally (Achenbach, Edelbrock, & Howell, 1987; Eisert, Walker, Severson, & Block, 1989); and of recent epidemiologic studies of children with emotional or behavioral disorders, only two of eight included children as young as 4 years of age (Brandenburg, Friedman, & Silver, 1990).

Current Identification of Emotional or Behavioral Disorders in Head Start

Any discussion of identification of children with emotional or behavioral disorders in school or school-related settings is complicated by issues of proportional underidentification of such children, in comparison to children in other disability categories, and of problems in school definitions of this category of disability (Forness & Kavale, 1989; Forness & Knitzer, 1992; Steinberg & Knitzer, 1992). Nonetheless, it is instructive to consider the proportion of children identified in the major categories of special education in the school years (6 through 21) as well as the proportion identified in comparable Head Start categories of disability. Table 1 provides comparable data by five major special education categories: learning disabilities (LD), speech or language impairments (SLI), mental retardation (MR), serious emotional disturbance (SED), and other (all remaining categories including orthopedic, sensory, and multiple disabilities). These data are taken from recent

annual reports on the Individuals with Disabilities Education Act (IDEA; U.S. Department of Education, 1991) and on children with disabilities in Head Start (U.S. Department of Health and Human Services, 1991), respectively, at comparable points in time. The data are presented in numbers by category along with the proportion of all children these numbers represent in the resident population from 6 to 21 years and 3 to 5 years, respectively.

TABLE 1
*Number and Percentage (by Resident Population) of Children
Identified as Eligible for Special Education*

	IDEA, Age 6-21 ^a		Head Start, Age 3-5 ^b	
	Number	Percentage	Number	Percentage
LD	2,064,892	3.6	3,771	.03
SLI	976,186	1.7	45,175	.41
MR	566,150	1.0	2,610	.02
SED	382,570	.7	3,096	.03
Other	271,878	.4	12,946	.12
Total	4,261,676	7.4	67,598	.6

^aSource: U.S. Department of Education (1991)

^bSource: U.S. Department of Health and Human Services (1992)

Note that over 4 million children with disabilities are being served in the 6-to-21 year range and just under 68,000 in Head Start in the 3-to-5 year range. Although the mandate for Head Start is to serve at least 10% of their population with identified disabilities, these programs currently serve 13.5%, exceeding their mandate by about one-third. The total children with disabilities served in Head Start is, however, only 19.2% of the 352,527 children, ages 3 to 5, served under the early childhood amendments to IDEA.

With regard to specific disability categories, LD is the largest category in the 6-to-21 year range but among the smallest in Head Start, obviously because of the problems in identifying disabilities in academic areas prior to their becoming a substantial part of the curriculum. Speech or language impairments are by far the most prevalent disability in Head Start, outnumbering the remaining categories by a factor of more than two to one. There is speculation, however, that some children in the latter category may indeed have symptoms that will have been precursors to the former, as these children later become identified in the elementary years (Forness & Kavale, 1989). Although physical and sensory disabilities (i.e., other) are relatively rare as primary categories of disability in the 6-to-21 year population, these disabilities represent almost one of every five children served in the Head Start disability categories. As shown, both the MR and SED categories remain relatively small in both age groups. There are no comparable disability categories reported for children ages 3 to 5 in the total non-Head Start preschool disability count noted above, since only 21 states currently serve children in this age range by disability categories under Public Law 99-457.

It seems clear that children with serious emotional disturbance remain relatively underidentified both in the school years and in the disability category of Head Start programs. In the school years, SED constituted only 9% of children identified with disabilities, and in the preschool Head Start children, it is only 4.6%. Over 27% of the SED Head Start population were reported as having "multiple disabilities" (U.S. Department of Health and Human Services, 1991). Children with SED in Head Start are thus identified at a rate that is close to half of children with SED identified in the school years.

It is important to note the differences in definition between IDEA and Head Start for serious emotional disturbance. The Head Start Definition is as follows:

A child shall be considered seriously emotionally disturbed who is identified by professionally qualified personnel (psychologist or psychiatrist) as requiring special services. This definition would include, but not be limited

to, conditions that indicate the child is: dangerously aggressive toward others, self-destructive, severely withdrawn and noncommunicative, hyperactive to the extent that it affects adaptive behavior, severely anxious, depressed or phobic, or psychotic. (U.S. Department of Health and Human Services, 1991, p. 32)

The IDEA definition of SED, as most readers are aware, focuses instead on five criterion areas involving (a) inability to learn, (b) inability to maintain satisfactory relationships, (c) inappropriate behavior or feelings, (d) pervasive mood of sadness or depression, and (e) tendency to develop physical symptoms or fears. This SED definition, moreover, excludes children who are socially maladjusted. As can be seen, such an exclusion would not seem to apply in the Head Start SED definition, and symptoms such as aggression or hyperactivity are specifically mentioned in Head Start although they are commonly reasons for an automatic social maladjustment exclusion in the SED definition for schoolage children (Forness & Knitzer, 1992). The conditions listed for SED in Head Start, in these and the remaining instances, would not only seem to be more inclusive than the SED definition under IDEA but would also seem to be somewhat more "user friendly" for professionals in mental health. The seven Head Start SED conditions are much more aligned with psychiatric diagnostic nomenclature than are the five conditions in the SED definition under IDEA (Forness & Kavale, 1989). Note also that either a psychologist or psychiatrist must identify such children in Head Start, while there is no such requirement in IDEA.

Developing Procedures in Head Start Screening for Emotional or Behavioral Disorders

Relatively little attention has been paid to specific procedures used in screening children in Head Start for disabilities and special education eligibility. The current process includes five steps (U.S. Department of Health and Human Services, 1991).

For any child who is suspected of a disability by parents or staff or who is referred from other agencies for Head Start disability services, the *first* step involves an interdisciplinary diagnostic team or "a professional qualified to diagnose the specific disability" (U.S. Department of Health and Human Services, 1991, p. 21) who makes a categorical diagnosis. The *second* step is a functional assessment by the same individual(s) "that describes what the child can and cannot do and identifies areas that require special education and related services" (U.S. Department of Health and Human Services, 1991, p. 21). The *third* step is the development of an individual educational plan (IEP), a process that appears similar to standard IEP procedures although relatively few specifics are given as to format, content, and the like. Parent participation is required. The *fourth* step involves ongoing assessment by the diagnostic personnel, the parents, and/or the Head Start teacher, with modifications of the plan as needed. The *fifth* step is arranging for continuity of services as the child makes the transition to public school programs. This may involve updating assessment information, exit interviews with parents explaining services needed, and transferring the files to the school or related agencies with parental consent.

It should be noted that, in addition to the 67,598 children currently identified in Head Start as eligible for disability services, another 21,902 were screened but not found eligible; thus, over 17% of all children in Head Start receive diagnostic services but only about three-fourths of these eventually are found eligible (U.S. Department of Health and Human Services, 1991). Nearly 60% of Head Start children identified with disabilities received some services from other agencies outside of Head Start; and a variety of parent services were offered which primarily involved education regarding their child's disability and opportunities to observe or participate in Head Start classrooms.

Sinclair and her colleagues (Sinclair, in press; Sinclair, Del'Homme, & Gonzalez, 1993) have been involved in determining eligibility for both special education and mental health services under an ongoing contract from one Head Start agency to the University of California, Los Angeles. The agency serves some 900 children annually of whom 60% are male, 65% are Hispanic, and 30% are Afro-American. About 40% are from single parent families. Only 33% of parents have completed ninth grade or above, and 50% are on

welfare or public assistance. Sinclair's diagnostic team consists of licensed educational psychologists and special education teachers. Over a recent period, a total of 159 children were evaluated and 151 of these were found eligible. Allowing for children who remain in the program for more than 1 year, some 16% thus were found eligible for special education. Of the 151 children found eligible, Sinclair (in press) found the following proportions in disability categories: 29% with EBD, 26% with LD, 18% with SLI, 7% with MR, and 19% with physical or sensory disabilities. These proportions contrast somewhat with national figures cited earlier in which almost 90% of children found eligible are either in the SLI or other (sensory or physical disability) categories.

That EBD was the largest category in the Sinclair study may be due, in no small part, to the fact that careful procedures were used to screen and identify emotional or behavioral disorders. In addition to usual mental health procedures, a subsample of subjects was screened with a systematic procedure previously not used with preschool children (Sinclair et al., 1993). This procedure involved a modified version of the *Systematic Screening for Behavioral Disorders* (SSBD; Walker & Severson, 1990). The SSBD is a comprehensive, multigate screening procedure involving teacher nomination, adaptive and maladaptive teacher rating scales, an index that identifies critical events that may not be reflected in teacher ratings, and independent academic classroom and playground social observations. Each step has clinical cutoff points based on normative, empirical data; the reliability and validity of the SSBD have been extremely impressive (Walker et al., 1988; Walker et al., 1990). Sinclair's modification of the SSBD involved substituting two additional playground observations for the two classroom observations since it was not practical to observe engaged academic time in Head Start classrooms that stress primarily play behavior and socialization (Sinclair et al., 1993).

In the Sinclair study, research was done on a subsample of 90 children in three classrooms (Sinclair et al., 1993). Of the 90 children, 36 met clinical criteria for teacher nominations, and 21 of these met clinical criteria on teacher ratings and critical events; 5 children met criteria in the final stage of playground observation for a prevalence rate of almost 6%. This rate is obviously much greater than the prevalence rates of EBD for schoolage children and for other Head Start programs.

With regard to screening Head Start children for EBD, as well as for other special education categories, early intervention is effective (Zigler & Muenchow, 1992). A strength of Head Start is that it has been found to reduce the need for special education placement by almost half (Lazar, Darlington, Murray, Royce, & Snipper, 1982) though much has changed in special education since the initial studies were completed in this area. A large scale study is currently underway of children who transition from Head Start (C. Ramey & S. Ramey, 1992). In this study, some 9,600 Head Start children across 31 states will be followed into third grade to determine the impact of delivering comprehensive transition services similar to those provided in Head Start. Half the sample will receive transition services and their progress will be compared with that of children who received Head Start but not the transition services throughout the early grades. An additional 9,600 children who did not receive Head Start will also be randomly assigned to transition and non-transition classrooms as contrast subjects.

In addition to special education eligibility of each group as determined by local school district personnel, a variety of core data instruments will be used to measure special education needs, irrespective of whether a child is referred for special education in the natural course of her/his schooling. These will be given at period intervals throughout the 4-year period and, as currently planned, include *School Archival Records Search* (SARS; Walker, Block-Pedego, Todis, & Severson, 1991), the *Social Skills Rating System* (SSRS; Gresham & Elliott, 1990), *Peabody Picture Vocabulary Test-Revised* (PPVT-R; Dunn & Dunn, 1981), *Woodcock-Johnson Psychoeducational Battery-Revised* (Woodcock & Johnson, 1989), and *What I Think About School* (Reid & Landesman, 1988) which is an open-ended interview about school and social supports.

As can be seen from the above list, some instruments — particularly the SARS and the SSRS — have clinical cutoff points that can be used to determine some indication of

risk for emotional or behavioral disorders. There are other more comprehensive instruments that indeed might have been used but lack of further resources and time constraints also needed to be considered. With the combination of standardized instruments and careful recording of special education referrals or eligibility as these naturally occur, this investigation will potentially provide scrutiny of initial Head Start determinations of EBD eligibility and their subsequent significance.

CONCLUSION

The above discussion demonstrates how Head Start would seem to have a special significance for early identification of children with emotional or behavioral disorders, especially given the overlap of several risk factors associated with poverty and the occurrence of emotional or behavioral disorders in the later school years. As has been discussed, children with EBD are currently underidentified in Head Start programs, as they are in the school years. However, preliminary studies of Sinclair and her colleagues that are reviewed herein suggest how systematic screening procedures for this category in particular appear to identify Head Start children in numbers closer to expected prevalence rates for emotional or behavioral disorders. As has been pointed out, studies in progress may more carefully delineate the natural course of these disorders as children make the transition from Head Start and move through the early school years.

The general process of early identification of emotional or behavioral disorders in the preschool years is nonetheless a more difficult enterprise than their identification in the primary grades. Beare and Lynch (1986) have pointed out that several factors may serve to diminish the effectiveness of such early screening programs including lack of willingness of parents to participate, low proportion of enrollment of children in organized preschool programs, inaccurate census data, and the like. Their data also demonstrate great variations in behavior perceived as typical in the preschool years, as has been borne out by other investigations (Achenbach et al., 1987; Stallard, 1993).

What then are the implications for practice in this area? One of the more pressing needs is the development of effective preschool screening instruments. Although Achenbach and his colleagues have produced an effective measure for diagnosis of emotional or behavioral disorders in very young children (Achenbach et al., 1987), this methodology may prove to be too cumbersome for efficient and economical screening of large numbers of preschoolers. Walker, Feil, and Severson (1992), however, are currently adapting the SSBD on a normative sample of preschoolers. Their multiple-gating approach, in which teacher nominations and subsequent teacher ratings or independent observations are made only on relatively small groups of children meeting clinical cutoff scores, would seem to hold special promise for Head Start settings. It is also important to note that the six risk factors noted above as characteristic of children in Head Start would further seem to suggest that multiple agencies need to be involved (Mattison & Forness, in press; Nelson & Pearson, 1991) so that screening and diagnosis even in the early preschool years may ultimately involve several professional disciplines and multiple service agencies.

Training of Head Start staff in early detection of emotional or behavioral disorders is also a priority. While implementation of early screening through measures such as the forthcoming preschool version of the SSBD may indeed sensitize Head Start teachers to characteristics of these disorders, other approaches may also be worthwhile. Teacher assistance teams have been shown to be effective with schoolage children (Chalfant & Pysh, 1989) and could indeed prove adaptable to Head Start classrooms as well. Teams of experienced or specially trained Head Start teachers could be developed and supervised by special education staff funded through existing federal early childhood amendments. Such teams could also provide early intervention for emotional or behavioral disorders as part of the initial screening process. As noted above, interagency or interdisciplinary referrals and treatment are an integral part of the Head Start mandate, and collaborative training in this area would also be essential.

Head Start continues to be seen as an effective intervention program (Zigler & Muenchow, 1992). Its potential for early identification and intervention for children with disabilities

is also becoming more visible; yet as noted above, its particular procedures and programs for children with emotional or behavioral disorders are less than satisfactory. The case for Head Start as a particular venue for screening for emotional or behavioral disorders and ways to enhance this process have been discussed herein. It would be prudent for professionals in special education and related fields to collaborate with Head Start personnel in developing the potential of this program to serve children with emotional or behavioral disorders at the same level it now serves children with other disabilities.

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The Social Maladjustment Issue Revisited: How Confident Are School Psychologists and Special Education Teachers in the Decision-Making Process?

Stephanie Stein and Kenneth W. Merrell

ABSTRACT

The difficult task of distinguishing between students with serious emotional disturbance and those with social maladjustment continues to present a problem for educators. Although many researchers in the field of special education and school psychology have strong opinions about the feasibility of differentially identifying these groups of students, very little information is available about how this distinction is actually made by educators in the field and the confidence that educators have in their ability to make this distinction. The purpose of this study was to investigate the factors that some multidisciplinary team members, specifically school psychologists and special educators, consider in making the distinction between students with serious emotional disturbance and students with social maladjustment, the degree of confidence they have in their ability to identify students with social maladjustment, and how responses from those with low confidence differ from those with high confidence. Although no significant difference in reported confidence was found between the two groups of professionals, there were definite differences between the professions in how those with low confidence and high confidence responded on descriptors identified as characteristics of students with social maladjustment by one or both groups.

Since the passage of the Education for Handicapped Children Act in 1977, special education personnel have struggled with the issue of determining whether children with behavior problems should be included or excluded from special education services. The federal criteria for identification of students with serious emotional disturbance (SED) excludes from identification those with social maladjustment (SM) unless they also have a serious emotional disturbance (U.S. Dept. of Health, Education, and Welfare, 1977). The difficult task of distinguishing between children with SED and children with only SM continues to present a problem for educators, primarily because the definition of social maladjustment has not been agreed upon (Center, 1990; Skiba & Grizzle, 1991, 1992; Weinberg & Weinberg, 1990; Zabel, 1986).

In the absence of any formal definition of social maladjustment, educators and researchers have dealt with the exclusionary clause through a variety of strategies ranging from equating social maladjustment with conduct disorders (Cheney & Sampson, 1990; Slenkovich, 1983) or delinquency (Clarizo, 1992) to ignoring the question of social maladjustment altogether and focusing only on the severity of the behavior problem (Weinberg & Weinberg, 1990; Zabel, 1986). The Council for Children with Behavioral Disorders (CCBD) is one of 30 professional groups that have joined together to advocate for a new definition of emotional or behavioral disorder (EBD, Forness & Knitzer, 1992). This proposed definition from the National Mental Health and Special Education Coalition would eliminate the exclusionary clause for social maladjustment.

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Some experts in the field of special education have tried to assist educators in this differential identification process by providing descriptive guidelines for identifying children with SED and SM (Clarizo, 1987; Kelly, 1986, 1990; Slenkovich, 1983, 1992). Clarizo (1987) developed a list of 20 characteristics, 11 of which school psychologists use to distinguish reliably between SED and SM. Based on his findings, students with SED would be described as being self-critical, naive, tense, fearful, ignored or rejected by peers, having consistently poor adaptive behavior, and suffering from an affective or emotional disorder. In contrast, students with SM supposedly experience little remorse for their misbehavior, act streetwise and tough, have adaptive behavior that varies from situation to situation, have older friends that get into trouble, blame others for problems, and have a character or personality disorder.

Similar distinguishing characteristics have been proposed by Kelly (1986) who equates social maladjustment with the term *conduct problems* (CP). The major distinction between SED and CP, according to Kelly, is that students with CP see themselves as normal and are capable of behaving appropriately but instead choose to break rules and violate norms for acceptable behavior. In contrast, students with SED are more likely to have a disturbed self-concept and exhibit emotional and behavioral problems due to internal psychological disturbances beyond their control. Finally, Slenkovich (1983, 1992), an outspoken expert on special education law, has taken the position that social maladjustment is synonymous with the DSM III-R (American Psychiatric Association, 1987) conduct disorders definition.

Conversely, many experts in the field of special education and behavioral disorders propose that the two groups of children cannot and should not be distinguished from each other when determining eligibility for special education services and that any attempts to distinguish between students with SED and SM are based on psychometric, conceptual, and ethical errors (Bower, 1982; Center, 1990; Cline, 1990; CCBBD, 1990; Forness, 1992; Nelson, Rutherford, Center, & Walker, 1991; Raiser & Van Nagel, 1980; Skiba & Grizzle, 1992; Weinberg, 1992).

According to some authors (Cline, 1990; Forness, 1992), the vague and imprecise definitions of social maladjustment currently available lead to unreliable, biased decision making. Similar concerns about the vagueness of definitions have been plaguing the field of special education for years as educators have tried to agree on other handicapping conditions such as learning disabilities (Epps, McGue, & Ysseldyke, 1982). The current concern is that schools may rely on the vague nature of the SM definition to exclude any students who the district simply does not want to serve (Maag & Howell, 1991; Nelson, 1992; Nelson et al., 1991).

The poor reliability of the SED/SM decision-making process is not only due to vague definitions but also to inadequate assessment technology for making distinctions between the groups (CCBD, 1990). Very few instruments have been validated for the purpose of differential identification of students with SED and SM (Nelson et al., 1991) and those that claim to make this distinction are viewed with considerable skepticism by experts in the field (Skiba & Grizzle, 1991; Nelson, 1992). Furthermore, the fact that characteristics typically associated with SM and SED often occur together (Kovacs, Paulauskas, Gatsonis, & Richards, 1988; Skiba & Grizzle, 1992) make the efforts to distinguish between the two especially difficult and questionably feasible. In addition, most of the students served in special education under the classification of SED display externalizing behavior problems supposedly associated with SM.

It has also been argued that there is precedent, both historical and legal, for providing special education services for students with SM. Consequently, removing these services would be a step backward in terms of addressing the individual needs of all students (Bowers, 1982; Nelson, 1992; Skiba & Grizzle, 1992).

Finally, there are serious ethical considerations in excluding these children from special education and ultimately school. In many cases, the special education decision-making process serves as a transitional point where schools decide whether they will give a student the added protection and services available through special education or whether

the student will be expected to cope on her/his own in the school environment. Without the protection provided by special education law, students with SM can and often are denied a free appropriate education within the public schools (Nelson et al., 1991; Nelson, 1992). Though little research is currently available on the long-term differential effects of the inclusion or exclusion of students with behavior problems from special education services, the potential for dramatic differences in outcome are great (CCBD, 1990).

One would expect that, given the controversial nature of this decision, educators on multidisciplinary teams (MDTs) may differ in how confident they are in distinguishing between students with SED and SM. There is already a substantial body of research to suggest that there are many potential problems or weaknesses with the MDT decision-making process (Pfeiffer, 1980, 1981; Poland, Ysseldyke, Thurlow, & Mirkin, 1982; Ysseldyke, Algozzine, & Mitchell, 1982). The purpose of this study was to identify the characteristics that some key MDT members, specifically school psychologists and special educators, believe are significantly more likely to be found in students with SM rather than in students with SED. Although there are many different roles represented on MDTs (i.e. regular education teachers, nurses, speech teachers, etc.), school psychologists and special educators were selected for this study because they are considered to be the most influential members of MDTs (Gilliam & Coleman, 1981; Pryzwansky, 1981). In particular, differences in responses from educators with low confidence in their ability to make the SED/SM distinction and those with high confidence were compared.

METHOD

Subjects

The subjects for this study are a subset of a larger group of respondents for a previous study (Stein & Merrell, 1992). For the present study, questionnaires were sent to a total of 420 school psychologists and special education teachers in Oregon and Washington.

The names of school psychologists were gathered through membership directories of relevant professional organizations (National Association of School Psychologists or the local state organizations). In most cases, the names of special education teachers were not directly available so letters were sent to special education directors (listed in state directories) with the request to give the questionnaire to a special education teacher in their district who was experienced in participating in SED eligibility decisions. A stratified sampling procedure was used for both groups of educators where every "nth" name or district in the directories was selected.

Selected were 210 respondents from each of the professions with an equal split between Oregon and Washington respondents. A total of 226 completed questionnaires were returned (54% return rate). The return rates between the professions and between the two states were quite similar, ranging from a low of 50% from special education teachers in Oregon to a high of 61% from school psychologists in Washington. Only one mailing was conducted with no follow-up mailing for nonrespondents.

Instrument

The authors designed the questionnaire for this study in order to investigate the factors that different professional educators use in making the distinction between SED and SM when determining eligibility for special education services. The questionnaires sent to respondents in Oregon and Washington were identical in all aspects except for the name of the handicapping condition; in the Oregon questionnaires, the term *seriously emotionally disturbed* (SED) was used whereas the Washington questionnaires used the term *seriously behaviorally disabled* (SBD). Although the terms differ between the states, the criteria for each category are almost identical, both closely paralleling the federal definition for SED. For the purposes of clarity, the term SED will be used throughout the rest of the study although it is also inclusive of the those students identified with SBD.

Respondents to the questionnaire indicated whether or not they had experience in making the distinction between SED and SM and how confident they were in their ability to make this distinction. The questionnaire also asked respondents to review a list of 27

behavioral or background descriptors and indicate whether the particular descriptor was important or not in making the distinction between the two groups. If the descriptor was rated as important, the respondent was then asked to make a forced choice, indicating whether the characteristic was more likely to be found in students with SED or noneligible students with SM. Although it is technically possible to be identified with both SM and SED, the respondents in this study were required to choose one or the other.

The behavioral and background descriptors used in this study were developed by the authors after reviewing the distinctive factors described by Clarizo (1987), Kelly (1986, 1990), and Slenkovich (1983, 1992), criteria for the DSM III-R diagnosis of conduct disorder (APA, 1987), and state and federal definitions of SED. In addition, several descriptors were included by the authors, based on their professional experience, to reflect some of the characteristics used by MDTs to make the distinction between the groups. The original 27 descriptors used in this study are listed in Table 1.

TABLE 1
*Original Descriptors of Child Characteristics Used to Distinguish
Between Students With SED and SM*

Violates rules	Discomfort w/ own behavior	Able to comply
Friends older/into trouble	Tense and anxious	Diagnosis of conduct disorder
Low academic skills	Ignored/rejected by peers	Aggressive behavior
Not in control of behavior	Depressed/sad	Feels something wrong w/ self
Truant from school	Poor self-concept	Feels guilty when misbehaves
Blames others for problems	Has problems in many settings	Distorted view of reality
Fights w/o provocation	Irresponsible behavior	Victim of abuse
Family mental health problems	Cruelty to animals/people	Bizarre thoughts/perceptions
Destructive of property	Socially immature	No behavioral improvement

Analyses

The overall confidence of the respondents in making the SED and SM distinction was rated on a Likert-type scale of 1 to 5 with 1 indicating no confidence and 5 indicating extreme confidence. The mean confidence ratings for the two groups of respondents were compared using a one-way ANOVA. In addition, a series of chi-square analyses were conducted. The chi-square procedure is a nonparametric test used when data are categorical in nature (i.e., SED or SM). The purpose of the chi-square is to test whether the actual obtained frequencies or proportions in each category are similar to or different from the expected frequencies or proportions for the population.

The chi-squares were conducted separately by profession on the 27 descriptors to determine whether respondents were more likely to categorize the particular descriptor as a feature of SED or SM. For example, within the group of school psychology respondents, the percentage that categorized "violates rules" as "more likely in SM" were compared to those who categorized this same descriptor as "more likely in SED" in order to determine whether there was a significant difference between the actual percentage of respondents in each category and the expected percentage of respondents (equally split between categories). The same procedure was followed for the special educators on each descriptor.

A total of 8 out of the 27 descriptors were identified by one or both groups as characteristic of SM. A similar analysis of characteristics associated with SED was not conducted for this particular study because the primary focus of interest was the issue of SM identification. The SM descriptors were examined to determine how respondents with little or no confi-

dence in their SED/SM decision-making ability differed from respondents who claimed to be very or extremely confident in this decision-making process. Respondents who gave medium confidence ratings (somewhat confident) were eliminated from this further analysis. Differences in the proportion of respondents from each group with low confidence and high confidence were summarized for each of the eight descriptors.

RESULTS

The average confidence ratings of school psychologists ($M = 3.02$, $SD = .93$) and special education teachers ($M = 2.81$, $SD = 1.04$) were compared using a one-way ANOVA. No significant difference in confidence was found between the two professions ($F[1,218] = 2.43$, $p = .120$).

Based on the initial series of chi-square analyses, each of the 27 descriptors was categorized as SED, SM, or not important (NI) for each of the two groups of professionals. In an effort to minimize the experimenter-wise error associated with conducting a large number of analyses, a conservative probability level of .001 or lower was used to indicate a significant difference. Four of the descriptors were identified as characteristic of students with SM by both groups of educators (violates rules, able to comply, friends older/get into trouble, and truant from school) and another four SM characteristics were identified by the school psychologists, but not the special education teachers (diagnosis of conduct disorder, blames others for problems, irresponsible behavior, and destructive of property). The responses on the eight SM characteristics were broken down within each group into low confidence and high confidence subgroups. The proportion of responses for each subgroup on the eight SM characteristics are listed in Table 2.

Classification differences between respondents with low confidence (LC) and respondents with high confidence (HC) on each descriptor were expressed in terms of a positive or negative difference score. When the proportion of SM responses increase from the LC group to the HC group, the difference score is preceded by a "+", indicating a greater proportion of respondents. Similarly, a "-" or negative difference score indicates that the proportion of SM responses decreased from LC group to HC group. The difference scores between the LC and HC subgroups for each descriptor are displayed in Table 2.

For school psychologists, the difference score from the LC to HC group was positive for each of the descriptors, indicating that as confidence increased, the school psychologists were more likely to identify the descriptor as characteristic of students with SM. In contrast, the difference scores for the special educators were negative for four of the eight descriptors (violates rules, able to comply, truant from school, and blames others). In other words, as confidence increased for special educators, they were *less* likely to identify the descriptor as characteristic of students with SM and more likely to identify the characteristic with SED or as "not important." On the remaining four descriptors, the positive difference scores for special educators were less than the school psychologists' difference scores, in some cases by a large amount. For example, although both groups of educators were more likely to identify irresponsible behavior as a characteristic of students with SM as their confidence increased, the proportion of school psychologists increased 44% whereas the proportion of special educators increased only 11%. However, it should also be noted that in all but two descriptors the proportion of LC special educators that identified a descriptor as "more likely in SM" was already higher than the proportion of LC school psychologists. Therefore, it is not surprising that less change was found in the responses from LC to HC special educators on these descriptors.

DISCUSSION

Two of the main questions addressed in this study are which characteristics educators use to differentiate SM from SED and how differences in the educators' confidence levels affect their responses as a profession. The connection between conduct disorder and social maladjustment proposed by several well-known authors in special education (Clari-zo, 1987; Kelly, 1986; Slenkovich, 1992) received inconsistent support in this study. Unlike the school psychologists, the special educators in this study did *not* identify the

TABLE 2
*Percentage of Responses on SM Characteristics for Total Group
 and Low and High Confidence Subgroups and Difference Scores
 Between Low and High Confidence*

Descriptor	School Psychologist			Special Educators		
	NI	SED	SM	NI	SED	SM
Violates rules	5	13	82*	8	26	66*
low confidence	10	15	75	13	20	67
high confidence	0	13	87	4	38	58
Difference score	(-10)	(-2)	(+12)	(-9)	(+18)	(-9)
Able to comply with expectations	5	13	82*	4	14	82*
low confidence	9	14	77	4	10	86
high confidence	3	15	82	11	19	71
Difference score	(-6)	(+1)	(+5)	(+7)	(+9)	(-15)
Friends older/into trouble	11	2	87*	8	10	82*
low confidence	30	4	65	16	9	75
high confidence	3	0	97	10	10	80
Difference score	(-27)	(-4)	(+32)	(-6)	(+1)	(+5)
Diagnosis of conduct disorder	9	24	67*	11	44	45
low confidence	18	27	55	13	47	40
high confidence	3	27	70	7	50	42
Difference score	(-15)	(0)	(+15)	(-6)	(+3)	(+2)
Truant from school	9	5	86*	11	21	68*
low confidence	21	11	68	17	17	66
high confidence	3	7	90	8	31	61
Difference Score	(-18)	(-4)	(+22)	(-9)	(+14)	(-5)
Blames others for problems	13	23	64*	12	46	42
low confidence	21	32	47	21	31	48
high confidence	8	23	69	4	67	30
Difference score	(-13)	(-9)	(+22)	(-17)	(+36)	(-18)
Irresponsible behavior	21	17	62*	19	35	46
low confidence	59	12	29	30	33	37
high confidence	7	19	73	5	47	48
Difference score	(-52)	(+7)	(+44)	(-25)	(+14)	(+11)
Destructive of property	17	14	69*	18	42	40
low confidence	31	16	53	23	42	35
high confidence	4	11	85	8	48	44
Difference score	(-27)	(-5)	(+32)	(-15)	(+6)	(+9)

NI = Not Important

* $p < .001$

diagnosis of conduct disorder as an indicator of social maladjustment. However, two of the characteristics identified by both special educators and school psychologists as significant indicators of SM (rule violation and truancy) are essential features of conduct disorder according to the DSM III-R (APA, 1987). School psychologists also selected destruction of property as a characteristic of SM which is also noted in the definition of conduct disorder. However, none of the remaining characteristics identified by school psychologists only (blames others, irresponsible behavior) or both groups (able to comply, friends older/into trouble) are explicitly included in the DSM III-R diagnosis.

Other characteristics that were not identified by either group as "more likely in SM" but are included in the essential or associated features of the conduct disorder diagnosis include fighting, poor self-concept, low academic skills, cruelty to animals and people, aggression, and exhibiting problems in many settings. Therefore, the relationship

between conduct disorder and SM is more complex than some writers would suggest, according to this sample of school practitioners.

The differences between school psychologists and special educators in the definition of SM become even more evident when trends in responses based on confidence level are examined. As Table 2 indicates, the difference scores between the LC and HC respondents are fairly dissimilar for each group of educators. There are several possible ways to interpret these discrepant difference scores.

First of all, it appears that differences in confidence levels within the special educators group have relatively little effect on the identification of SM descriptors, at least in contrast with the school psychologists. Second, the results suggest that special educators as a group are in less agreement about the descriptors that differentiate students with SM from students with SED. In contrast, school psychologists as a group are in greater agreement about what descriptors constitute SM, especially as their confidence in their decision-making ability increases.

As Table 2 indicates, when confidence increases, both groups are less likely to identify descriptors as "not important" (NI). However, the proportion of HC school psychologists that identify a descriptor as NI is consistently lower than the HC special educators. This finding suggests that HC school psychologists may take a more confirmatory approach to classification, judging all behaviors to be significant features of a problem such as SM. This confirmatory approach has been supported in previous research on the special education decision-making process (O'Reilly, Northcraft, & Sabers, 1989). One may even be able to argue that school psychologists as a group are more *pathology seeking*. At the least, this finding suggests that school psychologists are more likely to view behaviors in dichotomous terms of SED or SM than are special educators who appear to take a more complex view of SM.

In summary, the results of this study suggest that, although there are moderate differences between how school psychologists and special educators view social maladjustment (agreement on 4 of 8 descriptors), the differences tend to become more pronounced as their confidence level in making the SED/SM distinction increases. With increased confidence, school psychologists become more confirmatory in identifying descriptors as characteristic of SM whereas special educators take a more disconfirmatory approach to SM. This is consistent with previous research (Johnson, 1980) which has shown that school psychologists have conceptions about special education classifications that are inconsistent with those of special educators. Another significant finding is that the diagnosis of conduct disorder and its accompanying behaviors are *not* clearly associated with SM, according to the respondents in this study. Even though school psychologists tend to associate conduct disorder and SM, they do not consistently identify the essential and associated features of this disorder with SM. Furthermore, special educators take an even more complex view of the conduct disorder/SM relationship.

Finally, the average ratings for both groups of practitioners fell in the "somewhat confident" range when asked about their confidence in being able to make the distinction between SED and SM. These are disturbingly low ratings, considering the importance of the decision (special education eligibility) and its potentially serious long-term outcome. Given these findings, it would seem advisable that MDT members engage in a overt process of discussing their varying definitions of SM so that all perspectives can be carefully evaluated. In addition, if school psychologists and special educators are willing to admit their relatively low confidence in the SED/SM decision-making process, the MDT as a whole may be more likely to proceed cautiously and carefully in making the controversial decision to exclude students with SM from special education eligibility.

Limitations and Recommendations for Future Research

There are several factors in this study that may limit the interpretation of the findings. First of all, no pilot study was conducted with the questionnaire prior to this study so problems in the questionnaire could not be identified before its administration. For example, the questionnaire did not ask for years of experience in the profession which could have had

a confounding effect on the results. In addition, the responses were gathered from a limited geographic region of the country (i.e., the northwest) where students with SED/SBD tend to be underidentified (less than 1%) compared to other regions (around 2%). Finally, the use of a questionnaire rather than direct observation of actual decision-making practices is a limitation. The individual perspectives and group dynamics present in a special education team decision-making process are probably quite different than individual responses to a questionnaire where there are no obvious contingencies or adverse consequences to consider (Pfeiffer & Naglieri, 1983).

Future research in this area should sample from a broader geographic region and consider the use of different data collection procedures other than an indirect questionnaire. Ideally, future research in this area could focus on the actual decision-making process as it occurs in the MDT meeting and would compare the confidence levels of team participants who ultimately make an SED eligibility decision with teams that choose the SM exclusionary clause.

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The Effects of Music on the Classroom Behavior of Behaviorally Disordered Youth

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ABSTRACT

This study was conducted to determine the effects of music on the behavior of adolescent students labeled as being behaviorally disordered. The six behavioral categories of aggressive motor, aggressive verbal, disruptive motor, disruptive verbal, nondisruptive-off-task, and on-task were observed to determine if the three conditions of sedative music, stimulative music, and no music influenced the frequency of these behaviors. The results indicate no significant differences between the three conditions on the frequency of any of the six behavior categories. These results, however, have several implications for use of music in the classroom.

A great many factors are believed to influence the behavior of schoolage students. According to Altshuler (1945), one of these factors — music — has always played an important role in helping to sublimate aggressive and destructive behaviors. Yet surprisingly, a review of literature concerning the effects of music on problem behaviors reveals a dearth of research endeavors. Even among these few studies, all of which contained methodological flaws, conflicting results were reported. For example, Rieber (1965) found that fast music produced higher activity rates in 5- and 6-year-old nonhandicapped children than did slow music. Reardon and Bell (1970) found opposing results when studying activity rates among severely retarded boys. Cerebral palsied students displayed varying results, with those who were spastic cerebral palsied relaxing more to stimulating music, and those with athetoid cerebral palsy relaxing more to sedative music (Schneider, 1954).

Using mood music, Lindecker (1954) and Love (1953) observed its effects on disturbed/disturbing youth. In the Lindecker study the subjects were of four types: runaways, those needing protection, "dangerous" youth, and youth being held for questioning by the police. A public address system piped music into four residential sections and the dining room during mealtime, worktime, bedtime, and when the group was in a "disturbed" state. Both the staff members and detainees rated the music as having a favorable effect. Love (1953) reported that if a fight or an argument erupted in the research setting, playing sedative music calmed the situation almost immediately.

One study evaluated the effects of music with students displaying socially unacceptable behavior in the academic classroom. Alward and Rule (1960), using fifth and sixth graders ($N = 14$), collected data by means of behavior checklists, surveys, questionnaires, and interviews. A music therapy program which included listening to music had been developed for use with these students. It was reported that music *seemed* to have a quieting effect on these children.

Knowledge regarding the effects and use of music in the classroom is quite limited due to the paucity of research and the lack of adequate design and controls in those studies conducted (McIntyre & Cowell, 1991). All contained subjective terminology and inadequate measurement and/or interpretation. This study attempted to document more definitively the effects of music on social behavior in the classroom by using more precise and objective dimensions. As an extension of previous studies, the subjects in this investigation were students labeled as behaviorally disordered. To obtain an overall picture of youth with behavioral disorders in general, the behavior of the group was the focus of this study as opposed to the behavior of specific individuals.

METHOD

Subjects and Setting

This study was conducted in a residential home/school for students labeled behaviorally disordered. The facility was located in a rural community (although the students were from home areas of varied population density) and housed students in grades 7 through 12. Although many were mainstreamed into local schools for part of the day, due to the disruptive nature of the students' behavior, all remained on the residential grounds for at least 50% of their classes. Teachers from the local public high school traveled daily to the residential school to provide the students with educational instruction. For the purpose of this study, only junior high and high school students were observed. The students were observed for 12 weeks during the daily 40-minute study period which was scheduled from 2:20 to 3:00 p.m. 5 days a week. A minimum of two observers collected data from behind one-way glass in an observation booth adjacent to the classroom.

During the observation period, one teacher, one aide, and 5 to 8 students were present in the classroom. The actual identity of the students present within the classroom varied daily. This is because there were two study rooms with the second being used for overflow. On the days when the study period was attended by more than 8 students, the first 8 pupils arriving in the observation setting remained and the additional students were instructed to proceed to the other classroom. The overflow classroom was not observed. This procedure provided an overview of student behavior in general. As stated previously, the behaviors of the group rather than those of individual students were the dependent variables. While it is true that individuals behave differently, the focus of this study was on the overall group behavior, not the behavior of any one student. Therefore, for the purpose of this study, the variety in the number and identity of students being observed was considered irrelevant.

Recording Procedure

Data were collected using a 10-second momentary time sampling procedure with sequential rotation (Powell, Martindale, Kulp, Martindale, & Bauman, 1977; Thomsen, Holmberg, & Baer, 1974). Each observer used a separate preprinted computer optical scanning sheet to record daily data. The behaviors were coded using five letters: A for aggressive motor, B for aggressive verbal, C for disruptive motor, D for disruptive verbal, and E for nondisruptive/off-task. A check mark indicated on-task behavior. Darkening the space in the lettered bubble(s) meant the student under observation was displaying the behavior(s) at the recording time. A cassette tape recorder emitted a tone every 10 seconds, cuing the observers when to observe and record data. The sequential rotation procedure (Thomsen et al., 1974) has been shown to be the most effective means of recording group behavior, the variable of interest in this study.

Two prerecorded 90-minute reels of tape, one containing sedative music (48 largo to 108 andante) and the other containing stimulating music (132 allegro to 184 presto), were given to the classroom teacher for use during the treatment period. A standard movie projector speaker was used to pipe music into the classroom.

Behaviors

Six behaviors were selected for this study as a result of having discussed with the teachers the various problems exhibited by students in the school. Observers were instructed to record aggressive motor, aggressive verbal, disruptive motor, disruptive verbal, nondisruptive/off-task, and on-task behaviors during the study. If two or more behaviors were occurring simultaneously, the observers were instructed to record all. Definitions were adapted from Brulle and McIntyre (1985) as follows:

Aggressive Motor: The student emits an action that appears to be aggressive either to her/himself, other students, staff members, or objects (e.g., hitting, throwing an object forcefully at another, turning over a table).

Aggressive Verbal: In a voice loud enough to be heard by the observers, the student emits a verbalization that appears to be aggressive in nature (e.g., cursing at

others, threatening others).

Disruptive Motor: The student emits an act that disrupts the ongoing study hall routine but is not aggressive in nature (e.g., tossing a pencil to another, propelling paper wads, making faces, running around, pencil tapping).

Disruptive Verbal: In a voice loud enough to be heard by the observers, the student emits a verbalization or noise that disrupts the ongoing study hall routine (e.g., humming, yelling out, mimicking animal sounds, making unusual noises, singing).

Nondisruptive/Off-Task: The student engages in actions that do not disturb other students but are nonproductive in nature (e.g., sleeping, putting on makeup, staring out of the window).

On-Task: The student engages in behavior that appears to be productive and task oriented in nature (e.g., reading a book, writing a paper, working on an art project, sewing).

Three 1-hour training sessions were conducted prior to the study to teach the observers how to record properly the six behaviors cited. A videotape of a staged classroom period was used to provide the observers with practice recording the target behaviors. After the baseline period and before the treatment period, a retraining session was conducted to protect against observer drift. The observers were blind as to the purpose of the study.

Music

For the purpose of this study, two types of music — sedative and stimulating — were selected according to specific criteria. Sedative music was defined by a metronome marking of ≈ 48 largo through ≈ 108 andante. All sedative pieces used were nonverbal. Examples of music selections included in the sedative category were "Clair De Lune" by Debussy and "Swan Lake" by Tchaikovsky. Stimulating music was defined by a metronome marking of ≈ 132 allegro through ≈ 184 presto. All stimulating recordings included vocals and were chosen from the "Billboard Hot 100" list just previous to the undertaking of this research. Although popular music changes over time, the metronome marking was the important consideration here, allowing for the use of standardized criterion.

Procedures

The treatment conditions of sedative, stimulating, or no music were randomly assigned to the sessions during the 45-day treatment period. A 15-day baseline recording period consisting of no music preceded the onset of treatment. A multi-element baseline design was used.

Just prior to the beginning of each study period (2:15 p.m.) during the treatment sessions, the classroom teacher placed the reel of tape randomly assigned for the day onto the reel-to-reel recorder kept in a storage room adjacent to the classroom. A speaker was placed inside the classroom. The music was played at 30 decibels, a level comparable to average background music. This procedure was followed only on the days when sedative or stimulating music was assigned; it was not followed on the days when the no music condition was assigned.

Three observers were used in this study. One observer served as the primary recorder and the other two served as reliability checkers. If the primary observer was absent, the person designated as reliability checker one became the primary observer with reliability checker two becoming reliability checker one for that day. An estimate of interobserver reliability was determined using exact interval agreement for 100% of the sessions. The overall reliability for the study was found to be quite high (92.54%).

At approximately 2:30 p.m. the observers prepared themselves for collecting data. They stationed themselves in the observation booth and began recording data at 2:35 p.m. Reliability checker two was responsible for starting the cuing tape at this time. He was also responsible for keeping all observers recording the correct student by frequently

calling out which behavior was being observed at the next emitted tone. Later, the experimenters compared the reliability checker(s) sheets with the primary observer's sheets for discrepancies. The total number of aggressive motor, aggressive verbal, disruptive motor, disruptive verbal, nondisruptive/off-task, and on-task behaviors were then tallied on the data sheets. The total for each behavior on each sheet was divided by 90 (the total number of recording intervals in a 15-minute period) to arrive at a percentage of intervals that the behavior was observed.

RESULTS

A Friedman two-way analysis of variance (Siegel, 1956) was used to determine if a significant difference existed between the three conditions and four of the behaviors studied. Those behaviors were disruptive motor, disruptive verbal, nondisruptive off-task, and on-task. No significant differences were found. No tests of significance were used to analyze the relationships between the three music conditions and aggressive motor behavior or aggressive verbal behavior since each behavior occurred only once during the 60-day experimental period.

While no statistically significant differences were found, significance was approached in the behavior of on-task ($\chi^2 = 3.23$, $df = 2$, $.20 > p > .10$). In this behavior, the difference occurred between the sedative and stimulating music conditions with the stimulating music resulting in less on-task behavior.

DISCUSSION

The purpose of this study was to investigate, under exacting and objective research conditions, the effect of different types of music on behavior. Contrary to previous research findings (Alward & Rule, 1960; Lindecker, 1954; Love, 1953; Reardon & Bell, 1970; Rieber, 1965), the findings of this study did not suggest that music has either a calming or arousing effect on undesirable behavior. However, one music condition (sedative) deserved further study as it may possibly promote on-task behavior. This is supported by Berland's (1970) early review of the literature in which he concluded that music enhanced concentration. A later research study by Richmond (1976) found this to be true among severely retarded individuals. With regard to students with emotional and behavioral disorders, Burleson, Center, and Reeves (1989) found that instrumental music promoted on-task behavior in psychotic boys while they worked on a color sorting task. Future research efforts may wish to focus on this area.

The present study did contain limitations which merit discussion and may provide guidance in future research efforts. The fact that no significant differences were found between the behaviors and the music conditions could be attributed to several possible factors. First is the possibility that music has no effect on behavior. Given the degree to which people listen to music and the reasons for doing so, this is unlikely. Perhaps the specific teacher and aide present in the classroom during the study had an influence over the behavior of the students that other persons might not have. For example, their level of bonding with the students or expertise in behavior management might be influential factors. The time of day the study was conducted (late afternoon) could also have been a factor related to the results obtained. Differing effects may have been noted if the study had been conducted in the morning or early afternoon when students were engaged in directed academic tasks or were less fatigued from the day's activities.

Additional factors may have influenced the results. Although metronome marking was believed to be the important consideration, perhaps if the music selections for this study were jazz, gospel, country/western, barbershop quartet, or something different from the top 40s and classical used, the findings might have been different. Because only overall results were examined, it is unknown whether certain behaviors observed occurred more during certain specific selections.

It is also unknown if the words rather than or in addition to the tempo of the music may have been influential. Future research endeavors will need to address these factors. Additionally, the age of the students (junior high and high school) may have had an influence on

the results as might have the setting (residential facility) and its location (rural community) in which the study was conducted.

Finally, using the class as the unit of analysis in the study and not the behaviors of the individual students could have negated individual effects due to music. Future research will need to examine the effects of music on the behaviors of individual students in addition to groups of pupils. Researchers may also wish to look at a larger number of subjects, a wider selection of music, various locations and settings, and different age and cultural groups.

The results of this study did not support the premise that music effects aggressive, disruptive, or nondisruptive/off-task behaviors. Rather, the results suggest that if music had any effects this study did not measure them. Future investigations, however, should emulate the characteristics of this study by utilizing adequate controls and design, objective terminology, exact measurement criterion, and an applied setting familiar to students.

The findings of this study extend previously conducted research and may be of value to administrators and teachers. For instance, teachers may choose to use background music to create a more welcoming and pleasant classroom atmosphere without the concern that students will be distracted from their academic tasks. This view is supported by research by Miller (1947) who found the playing of radio music during test administration to have "little or no effect on study efficiency" (p. 118), although Hilliard and Tolin (1979) found performance to be higher in the presence of familiar music than unfamiliar music which may support choice of music rather than teacher selection. "Theme music" might be used to set the mood for a certain lesson or activity, however (e.g., the theme from *Rocky* before a competitive event or *The Blue Danube* before and during the post-recess writing activity). Music can also be used as a motivating factor by making the playing of favorite recordings contingent upon students' on-task behavior. This motivational aspect might also be built into one's behavior management system as a reinforcing consequence for the display of positive, prosocial, or on-task behavior by individuals or groups.

These suggestions are speculative and their viability will be determined by future investigations. While these results are interesting and thought provoking, additional research must be conducted before a clarified perspective on the effects of music on student behavior can be fully determined.

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Promoting Social Skills Training in General Education Classrooms: Issues and Tactics for Collaborative Consultation

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ABSTRACT

Social skills deficits have a deleterious affect upon students' adjustment. School personnel increasingly are providing intervention that will ameliorate these deficits. These interventions typically focus on handicapped students or those identified as at-risk, and are conducted in isolated settings such as the special education resource or self-contained classroom. This approach, however, is antithetical to promoting social interaction in natural environments. This article focuses on the role special educators can play in providing consultation to assist general education teachers in implementing social skills training in their classrooms. Important topics of communication are described and recommendations for consultation are presented.

A growing number of students with learning and/or behavioral problems are being integrated into mainstreamed classes. Idol (1992) identified factors influencing this trend: litigation ensuring the right to a least restrictive educational experience, legislation at both state and federal levels, and support for those who advocate the Regular Education Initiative (REI). Each of these factors, to varying degrees, has affected societal views toward individuals with disabilities and the culture of schools. Change in attitudes and service options toward students with disabilities, however, has been slow, primarily because of the ingrained belief in the existence of what Sarason (1982) called the myth of two psychologies — one approach for *normal* child and another for the *special* child. This myth has partially been responsible for perpetuating the dual system of education as typified by the "pull-out" approach serving youngsters with disabilities. This system has reinforced the belief that general educators should not be expected to deal with students who deviate from the norm along intellectual, academic, and/or social dimensions.

While the debate over the extent to which students with disabilities should be integrated into general education classes has been heated and pervasive, there is far less disagreement concerning the potential social benefits all students may derive from this arrangement. For example, there is mounting evidence that students can learn to understand and respect individual differences, develop communication skills and friendships, and work cooperatively with others in integrated settings (e.g., Madden & Slavin, 1983; McHale & Simeonsson, 1980; Voeltz, 1982). These potential advantages, however, bring into question the goal of education. Traditionally, society has viewed the responsibility of schools as primarily to promote youngsters' cognitive and academic development to a sufficient degree that they become productive and contributing members of society. A second goal of education, which has never been taken seriously, is to inculcate students with the values appropriate for life in a democracy. These values, such as the importance of working cooperatively, can be promoted through social skills training (Sapon-Shevin, 1986). Mutuality in living, while not a new idea, has received new impetus in light of the debate over full inclusion.

Providing students with democratic values requires some modification in classroom structure and routine to foster social interaction. In essence, teachers must be willing to integrate social skills training into existing curricula and activities — a requirement that has been met with much resistance. Many teachers neither view the development of social skills falling within their purview nor believe that they have the time and expertise to implement a social skills training program. In fact, some general educators consider social skills to be the least important student behaviors exhibited in their classrooms (Kerr & Zig-

mond, 1986). Paradoxically, teachers generally feel better about children that have participated in social skills training (Zaragoza, Vaughn, & McIntosh, 1991). This somewhat schizophrenic view illustrates the difficulty achieving consensus on the importance of integrating social skills training into general education classrooms. To complicate matters, there is little consensus that students with behavioral disorders, for example, will be best served in general education settings (Braaten, Kauffman, Braaten, Polsgrove, & Nelson, 1988). Assuming the inevitability of full inclusion, only modest attention has been given to facilitating the transition of students with disabilities from more to less restrictive placements (Laycock & Tonelson, 1985). In addition, while special educators in general, and those working with students with behavioral disorders in particular, should possess expertise in social skills training (e.g., Cullinan, Epstein, & Schultz, 1987), many are insufficiently prepared to make the transition from special to general education classrooms (Laycock & Tonelson, 1985).

One approach for addressing the interpersonal needs of an increasingly diverse population of students being served in the general education setting is through the use of collaborative consultation. There is some data indicating that collaborative consultation, in combination with transenvironmental programing and student-directed interventions, can promote the successful integration of students with behavioral problems into least restrictive settings (Fuchs, Fuchs, Fernstrom, & Hohn, 1991). Collaborative consultation requires teachers to expand their roles and responsibilities. For example, instead of the narrow categorical responsibilities currently ascribed for teachers of students with behavioral disorders, assuming the role of consultant would allow them to use their expertise in behavior management and social skills training to assist general education teachers. Idol (1992) points to the fact that many states are recognizing general education classroom placement with consultative support as a legitimate and reimbursable service delivery option. Collaborative consultation allows special educators to reach larger numbers of students than through pull-out programs alone. Specifically, special educators could work with general education teachers to help them incorporate social skills training into existing curricular areas (Maag, 1992).

A variety of commercially-available social skills training curricula exists that provides standardized procedures that simplify the implementation process (see McConnell, 1987). In addition, social skills training interventions have been effective with students exhibiting a wide range of problematic behavior (Zaragoza et al., 1991). However, a myriad of factors impact upon the success of any social skills training curricula. For example, the relationship between student characteristics, intervention techniques, and situational variables is more complex than previously envisioned. Precise identification of skills and exact specification of performance expectations in given situations are difficult to ascertain (e.g., Fox, 1987). Moreover, identifying social skills deficits that cause youngsters to have problems with their peers is not always possible since causes of peer rejection or neglect typically are multiple and complex (Kauffman, 1989). Notwithstanding the complexities of the issues surrounding social skills, there is reason to believe they can be addressed satisfactorily through collaborative consultation (Maag, 1992). Perhaps a more fundamental problem facing special educators, however, is convincing teachers that, with consultation, social skills training can be incorporated into their daily classroom routine without adding substantially to their responsibilities.

Convincing general educators that social skills training represents an important undertaking — one that will benefit both teachers and students — requires the individual serving as consultant to communicate information that addresses several important topics impacting upon social skills training. First, a rationale for social skills training must convey the notion that promoting students' social competence is no different than promoting their academic competence. Second, it is important to stress that students' interpersonal difficulties should not be considered as evidence of a clinical disorder existing solely within the student. Instead, teachers should focus their attention on analyzing and modifying contextual variables that affect interpersonal competence. Third, social skills training should focus on all classroom members, and therefore, should be incorporated into exist-

ing routines and activities. Fourth, in order to integrate social skills training into existing programs, teachers must be willing to move away from traditional classroom management and instructional techniques and replace them with more participatory approaches that encourage student involvement and interaction.

Although communicating the above information is important for enhancing the effectiveness of social skills training, these recommendations are insufficient in and of themselves for ensuring a positive outcome. There are basic principles of collaborative consultation which should be followed in order to develop working relationships with consultees. For example, a central feature of collaborative consultation is promoting teacher empowerment and a shared ownership of problems while fostering the common goal of providing each student with the best possible program (Morsink, Thomas, & Correa, 1991). These skills will benefit all students and not just those with identified disabilities. For example, many youngsters who are withdrawn and rejected or neglected by their peers are at-risk for dropping out of school, juvenile and adult crime, and childhood and adult psychopathology (Parker & Asher, 1987). Students who are homeless, live in poverty, are victims of child abuse, and abuse drugs and alcohol also are at-risk for school failure — both academically and socially (e.g., Irvin & Maag, in press). Finally, individuals serving as consultants must be knowledgeable of issues that impact upon the efficacy of social skills training such as the role of assessment in selecting target behaviors and training interventions. The purpose of this article, therefore, is to provide information on important topics of communication, and present basic principles of consultation and recommendations for social skills training. By addressing these three areas, collaborative consultation may promote the successful integration of social skills training into classrooms and existing curricula.

TOPICS OF COMMUNICATION

Each topic described below is designed to provide information to help general educators contemplate the importance of and their ability to implement social skills training in their classrooms. Some of the topics focus on changing preconceptions commonly held by some teachers while others point to specific practices. All the topics are based on the assumption that promoting students' social competence is a relevant and important goal for all educators and not just one to be confined to students receiving special education services in isolated settings. Although teachers may readily acknowledge the deleterious effects social skills deficits have upon youngsters' functioning, they may not feel it is within their purview to remediate social inadequacy. Therefore, the first topic which consultants should communicate to teachers is that the distinction between social behavior and academic behavior is arbitrary.

Academic Behavior and Social Behavior

Teachers have been conditioned to view academic behavior and social behavior quite differently (Howell, 1985). University education programs usually offer separate courses that deal with these topics. In public schools, the popular belief about special education teachers is that those working with learning disabled students focus on academics, whereas those working with behaviorally disordered students focus on social skills. Consultants are faced with the challenge of convincing teachers that the distinctions between academic behavior and social behavior are fairly arbitrary: both are governed by similar principles of learning and respond to similar interventions (Kaplan, McCollum-Gahley, & Howell, 1988). While this line of reasoning may be philosophically appealing, it is a hard concept for teachers to accept. This distinction, regardless of how capricious it may be, is partially responsible for the prevailing view that teachers' primary responsibility is to produce academic behavior and control social behavior (Howell & Morehead, 1987). Parents hold a similar notion when they expect their children to be good but react to them with negative consequences when they are bad. It is common for parents to ignore their child when s/he is behaving in an acceptable manner — for example, using good table manners when eating at a restaurant. However, if the child is slouching in her/his chair or begins to throw food, the parent is quick to administer a verbal reprimand (i.e., punishment).

The view that good behavior is ignored and bad behavior receives attention is pervasive throughout our society. Prevailing cultural ethos dictates that punishment is more acceptable than rewards because the former does not threaten our autonomy — we believe we are free to choose to behave in responsible ways to avoid punishment. Conversely, rewards are seen as externally applied, thereby intimating that people behave in certain ways not because they are internally motivated but because they are being coerced (Skinner, 1971). Although punitive contingencies may be more inconspicuous than reinforcement (e.g., a student sits quietly to avoid the stern look from her teacher), the former is consistent with the concept of control and is antithetical to promoting socially competent functioning. Whereas control can be viewed as reactive, instruction is proactive and consists of preplanned activities and techniques to increase students' academic behavior and social behavior.

The *control mentality* is pervasive throughout education. Consequently, schools have developed elaborate management plans to decrease inappropriate social behavior (Neel, 1988). Teaching youngsters social skills will be a frustrating endeavor until teachers view misbehavior as an opportunity for increasing interpersonal functioning rather than something to be punished. To increase teachers' awareness of the deleterious effects of controlling social behavior, consultants can draw an analogy to mathematics instruction. Most teachers would readily agree that when students make mistakes in division the goal is not to *punish* or decrease division behavior. Rather, procedures are implemented to provide students with the correct strategy and practice to increase their competence in division. The same logic should apply for social behavior. This analogy is intended to reframe the problem to content familiar to general education teachers and sets the stage for describing how interpersonal functioning is contextually determined rather than being viewed as a deficit internal to the student.

Contextual Variation

All too often teachers attribute a student's lack of social skills to some condition or deficit that exists within the student. This view is consistent with the medical model used in psychiatry which considers behavioral problems to be clinical entities much like physical diseases. While some students lack requisite skills for behaving prosocially, this problem is readily correctable through direct instruction, and therefore, should not be considered proof of the existence of a clinical disorder. In addition, some students choose not to perform behaviors in their repertoire for a variety of reasons external to the individual (Howell & Morehead, 1987). Consequently, the medical model fails to acknowledge the influence of contextual factors and the interactive nature of social competence. By definition, social competence reflects mutually reinforcing interactive exchanges between individuals (Strain, Odom, & McConnell, 1984). This notion, referred to as social reciprocity, provides the rationale for examining and developing classroom contexts that are conducive for promoting students' social skills. In classrooms where interaction between students is discouraged, the chance for prosocial behaviors gaining a reciprocal response from peers is minimized. For example, in many special education classrooms, individual work folders and study carrels are the norm. In this context, a student may learn the skill of asking to join in a group activity yet run the risk of being punished for getting out of her/his seat. Consequently, the peers will be unable to reinforce the student's prosocial behavior. In this example, the classroom context must be changed to promote the acquisition and maintenance of social skills.

If classroom contexts reflect the goals of promoting social skills, then they should facilitate opportunities for students to interact. Unfortunately, teachers often implement classroom management systems that prevent the use of social skills (Neel, 1988). It is difficult, for example, to have students interact, argue, discuss, negotiate, and compromise if the class is set up so they are rewarded only for completing their tasks, sitting quietly in their seat, and only talking when they raise their hand. Similarly, it is difficult to create the need for solving problems, asking for help, or making do with what you have when all the assignments are put in folders, materials are readily available, and the teacher stands

ready to eliminate all road blocks. Therefore, it becomes much more beneficial to evaluate and label contexts rather than students (Maag & Howell, 1991). Socially incompetent behavior, then, is viewed as resulting from a *poor fit* between the student and her/his ecosystem — a system that typically includes peers, teachers, instructional tasks, classroom structure and activities, and the larger school community (e.g., Greenwood & Carta, 1987). Examining contextual factors rather than student characteristics results in an approach referred to as "program ecology" which directs intervention efforts at members of the student's social network, namely peers.

Focusing Intervention on the Peer Group

The obvious focus of social skills training is on teaching critical behaviors to the target student. However, Strain et al. (1984) consider shaping the social interactions of peers toward the target student as equally if not more important for advancing generalization. The student's peer group must be socially competent and provide reinforcement to the student for engaging in newly acquired social skills. This approach, known as promoting entrapment, requires restructuring existing reinforcement contingencies in peer interaction groups so that these new contingencies will maintain just acquired adaptive social behaviors exhibited by the student receiving training (McConnell, 1987). This approach truly is ecological as the foci of intervention include the peer group as well as the target student, and can only occur by analyzing contextual variables and the reciprocal nature of interactions between individuals. A variety of group-oriented procedures have been devised and discussed extensively elsewhere (see Greenwood & Hops, 1981). The point to be made here is that rather than assuming social skills deficits are individual-specific and require changing some discrete target behavior, treatment should focus on modifying interactions between the student and her/his peers.

The use of group-oriented procedures represents a method for promoting entrapment. For example, the members of a cooperative learning group activity are awarded points for each positive response to the initiations of the target student. The entire group, then, is given access to additional free time contingent upon the number of points earned and appropriate interaction rates between target student and group members. In this way, both the target student and peers initially receive direct, teacher-provided reinforcement for increased rates of positive initiations. After initial implementation, this group contingency can be faded to a more random schedule of reinforcement, thereby approximating rates of reinforcement that would occur more naturally between the behavior of the target student and her/his peers. This type of approach focuses on the interactive aspects of children's social behavior, provides a framework for creating interactions that will ultimately lead to entrapment of targeted social responses, and directly involves peers in the intervention process (McConnell, 1987). In order to use group-oriented procedures to promote entrapment, teachers must be willing to move away from traditional classroom management and instructional techniques and replace them with more participatory approaches that encourage student involvement and interaction.

Designing Classrooms to Promote Entrapment

There are a variety of procedures and activities for promoting student interaction. The addition of psychosocial activities to the curriculum can help improve scholastic learning by providing a more interesting class environment, creating more opportunities for personal development, and allowing the acquisition of new interpersonal skills (Lovitt, 1991). One such procedure was developed by Mills (1987) which was implemented in five phases: (a) relaxation sessions for reducing fidgety and tense behaviors in students; (b) magic circle activities to decrease the incidence of teasing, criticizing, and laughing at one another among students; (c) art sessions for helping students gain a better understanding of themselves through self-expression and working cooperatively with others; (d) future-planning groups for assisting students to think more realistically about their future; and (e) decision-making groups to aid students in making proper decisions and increasing responsible and autonomous behavior. Other similar programs for promoting social behaviors by involving

peers such as the Teaching, Learning, and Caring (TLC) curriculum (Vaughn, 1987) have been developed.

Although these programs have effectively increased positive social interaction among students exhibiting behavioral problems, they require teachers to find time to add them to their existing curricula and classroom activities. Many teachers rightly believe the demands and responsibilities of their job are sufficiently high, and consequently, are not particularly amenable to adding new curricula to their already full schedules. Therefore, teachers must be convinced that promoting social interaction and entrapment is not synonymous with adding new curricula but rather requires rearranging existing programs, lessons, and activities. For example, teachers can set up a place for students to work together (Neel, 1988). The use of work stations increases the amount of time students interact with each other while still meeting the academic goals of the existing curriculum. Students can use these stations to self-correct their work or obtain materials, ideas, and projects that encourage additional group practice of academic skills (Paine, Radicchi, Rosellini, Deutchman, & Darch, 1983). Different students can be put in charge of these work stations, supplies, and services. In order for students to function successfully at work stations, they either possess or are taught the necessary requisite skills.

In addition to the suggestions presented above, classrooms can be designed to promote entrapment by implementing two specific procedures: peer tutoring and cooperative learning. Peer tutoring is an effective method for educating a variety of students that benefits both tutor and tutee in numerous ways. For example, Jenkins and Jenkins (1981) noted that, in addition to gains in academic achievement, peer tutoring has positively impacted upon self-esteem, interracial integration, level of aspiration, personal confidence, and social adjustment. Scruggs, Mastropieri, and Richter (1985) concluded that peer tutoring with behaviorally disordered students exerts a positive influence on academic functioning of the tutee and tutor, and increases social relations of the tutoring dyad and attitudes toward the content area being tutored. Gains in social interactions for both students with and without behavioral problems is particularly germane to the present discussion. Maher (1982) found that students with behavioral problems who acted as tutors demonstrate improvements in their social functioning. Leary (1987) developed Interaction Place Maps to help increase interpersonal and communication skills between tutor and tutee. In this approach, students are presented with a sheet listing nine categories of interactions. Students then offer examples from their experiences that fall into each category and discuss each one. Teachers should find this and other peer tutoring techniques quite palatable since they can be implemented without adding content to the curriculum while simultaneously increasing academic engaged time, promoting more learning within a single lesson, and optimizing progress through the curriculum (see Jenkins and Jenkins, 1985 for a description of components and considerations for implementing peer tutoring).

Perhaps no one procedure has demonstrated such promise and is so perfectly tailored for promoting social interaction and academic gains among students as has cooperative learning. This approach requires a heterogeneous group of students to work together to achieve mutual goals. The essence of cooperative learning is positive interdependence — students recognize that they are involved in the task together — they sink or swim as one (Johnson, Johnson, Holubec, & Roy, 1984). Johnson and his colleagues maintain that, at their best, cooperative learning experiences enhance prosocial interactions, feelings of psychological acceptance and success, self-esteem, and the understanding of other students. In order for cooperative learning groups to promote prosocial interaction, it is important for teachers to observe participation patterns of group members such as who contributes ideas, asks questions, expresses feelings, actively listens, expresses support, acceptance, warmth, or liking, encourages all members to participate, summarizes, checks for understanding, relieves tension by joking, and gives direction to other group members. By examining these interaction patterns, teachers can set up situations for promoting entrapment while simultaneously enhancing students' academic performance.

Slavin and colleagues developed Team-Assisted Individualization (TAI) for promoting social acceptance and academic achievement of mainstreamed handicapped students by combining elements of cooperative learning, peer tutoring, and individualized instruction (Slavin, 1984; Slavin, Madden, & Leavey, 1984). TAI involves heterogeneous groups of four or five students working on math units appropriate to their instructional level. Students alternate between working problems and correcting each other's assignment using an answer sheet. If a student experiences difficulty on a problem, s/he seeks assistance from the group for help. Each student takes a checkout test scored by a team member after they correctly complete four problems in a row. Both individual and group scores are computed after students obtain 80% correct on the checkout test. The social behavior and academic behavior of students with mild disabilities, and their social acceptance among nondisabled peers, has improved as a result of participating in TIA groups (e.g., Madden & Slavin, 1983; Slavin, 1984; Slavin et al., 1984).

RECOMMENDATIONS FOR COLLABORATIVE CONSULTATION

One way special educators can help general education teachers move away from traditional ways of conceptualizing social skills deficits, interventions, and classroom curricula and activities is by assuming the role of consultant. Consultation, however, should proceed collaboratively so that teachers and counselors share ownership of the identified problem (Idol, Paolucci-Whitcomb, & Nevin, 1986). Collaborative consultation holds promise of alleviating teachers' fear that outside involvement reflects their inability to solve the original problem and perception that advice is being imposed without regard for their input. Idol et al. describe several advantages of collaborative consultation. First, social skills training interventions are enhanced when general and special educators share their expertise. Second, a collaborative approach helps facilitate participation in the intervention process among various professionals. Third, existing knowledge can be reorganized to foster creative solutions to complex interactions which must be analyzed for social skills training to be effective. In order for special educators to work collaboratively, they must possess knowledge of basic principles of consultation and provide specific recommendations for social skills training.

Basic Principles of Consultation

Numerous authors have described basic principles for collaborative consultation in school settings (e.g., Cole & Siegel, 1990; Hansen, Himes, & Meier, 1990; Idol et al., 1986). Various collaborative arrangements also have been developed that can be categorized according to type of problem foci (prevention or remediation), level of intervention (individual child, classroom, or school system), and approach taken by the consultant (expert or facilitative; Scholten, 1990). Similarly, various stages in the consultation process have been described using problem-solving theory as a framework (e.g., Bergan & Tombari, 1976; Conoley & Conoley, 1982). The following recommendations are based on principles for effective consultation.

Establish rapport. Rapport is essential for any collaborative relationship. In terms of consultation, establishing rapport helps all parties feel comfortable in expressing their ideas and feelings without fear of adverse judgments or rejection (Blake & Mouton, 1976). Treating teachers with respect and viewing them as equal partners is especially important in gaining acceptance. Special educators should stress that the consultative relationship is voluntary. A teacher who feels coerced into this relationship is unlikely to be an active participant in the process (Anserello & Sweet, 1990). The consultant also should stress that all parties share responsibility and hold equal status in the relationship. Obtaining active participation of the teacher is a benchmark that rapport has been successfully established.

Portray consultation as a problem-solving process. Consultants can either assume autocratic, democratic, or laissez-faire leadership styles. While there are some exceptions to the rule, Scholten (1990) recommended consultants assume a democratic style. This style fosters open communication and shared problem solving. There often is a tendency for teachers to perceive consultants as the expert, and accordingly, expect the latter to

solve the problem quickly. However, a problem-solving approach requires the teacher's input and active participation. Consequently, some teachers may experience role ambiguity and loss of confidence when the special educator moves out of traditional roles, relationships, and responsibilities (Maher, Illback, & Zins, 1984). Consultants can deal with this problem by first remaining passive which in turn encourages the teacher to begin discussing issues that commence the problem-solving process (Davidson, 1990). As the teacher becomes involved in the consultative process, the consultant can become a little more active but still remain in the teacher's frame of reference. If a teacher continues to defer to the authority of the consultant, a useful way of responding called "one downmanship" (Caplan, 1970) can be used. In this technique, when the consultant perceives that the teacher is deferring, the reply should be in a similar manner.

Downplay change. Change can make teachers uneasy regardless of how well the special educator has prepared them for the consultation process. Therefore, it is important to downplay the extent and nature of any changes in general education teachers' classrooms in order not to raise their anxiety level. Anserello and Sweet (1990) describe two ways to accomplish this goal. First, the special educator should portray consultation for social skills training as being similar to other activities appearing in students' IEPs which are already in place. As teacher acceptance increases, it will be possible for the consultant to introduce more fundamental modifications in the classroom. Second, consultants should ensure that changes are made gradually at times when teachers appear ready to accept them. For example, in helping teachers set up a place for children to work together to promote entrapment, it is important to suggest changing the physical structure of the classroom before changing activities (Neel, 1988). Making both changes simultaneously can be overwhelming.

Create opportunities. Many teachers view special educators' roles in terms of very traditional models. In these situations, role expansion poses significant problems. Teachers often lament the amount of extra time required to implement recommendations. This obstacle can be avoided by establishing credibility. Anserello and Sweet (1990) described several ways to reach this goal. First, consultants should avoid telling teachers what to do and instead provide a demonstration. Second, the school principal should be enlisted to persuade her/his staff of the benefits of consultative services. Third, consultants should maintain a high profile in the teacher's classroom. For consultation to be meaningful, it must be based on what actually goes on in the classroom setting. Consultants must observe and participate in teachers' classrooms. By "walking in the teacher's shoes," the consultant creates opportunities for collaboratively developing plans to promote students' prosocial interactions.

Apply principles of reinforcement. Consultants always should accentuate the positive changes both teachers and students make in the classroom. Teachers should be reinforced for attempting to change their classroom routine. By modeling positive reinforcement, consultants are more likely to entrap both teacher and student behaviors. For example, it is better to focus on what can be done to help the student rather than what is wrong with the student. This suggestion applies to all parties and stresses the idea of "catching each other being good." Although everyone has a common sense notion of rewards, very few people are aware of just how frequently they are influenced by positive reinforcement in all aspects of their lives. Although some stimuli are reinforcing for virtually everyone (e.g., food), it is important to remember that reinforcement is individual-specific.

Exude a preventative mind set. Focusing on prevention reflects the overall orientation of this article — be proactive rather than reactive, catch the student being good, rearrange the classroom to promote prosocial interaction, and so forth. Unfortunately, primary prevention is not usually a leading concern of most schools (Genshaft, 1984). Luckily, teachers have prolonged contact with their students and therefore are in a position to identify recurring interaction patterns which could place a child at-risk for future problems. Consultants need to tap this information by pointing out how it can be used to make classroom alterations before the problem gets out of hand and becomes all-consuming for the teacher to manage.

Specific Recommendations for Social Skills Training

In addition to basic principles of consultation, special educators need to be familiar with issues related to the role of assessment, target behavior selection, intervention, and outcome evaluation in social skills training. It is clearly beyond the scope of this article to present an in-depth discussion of these topics (see Maag, 1989, 1990 for reviews). Therefore, specific recommendations are presented that have been garnered from the social skills literature.

Collect functional assessment information. Assessment should provide information on the nature of observed performance deficits (Elliott, Gresham, & Heffer, 1987). All too often practitioners assume that, if a student is not performing a behavior, it must not be in her/his repertoire. Intervention efforts then focus on teaching the student the missing skills. Although performance deficits may be due to missing requisite skills, other factors should be considered including poor problem solving, selection of behavior automatically rather than consciously, and environmental antecedents and consequences that militate against competent performance (Maag, 1989). For example, a boy who possesses requisite skills for introducing himself and initiating a conversation but is nervous and subsequently fails to employ the behaviors would benefit from different intervention strategies than would a boy who simply lacks the requisite skills. In the former scenario, verbal mediation or relaxation training would be advisable. Functional assessment, therefore, requires conducting naturalistic observations and task analyzing performance as well as setting up role-play scenarios to assess performance, interviewing students, giving them self-monitoring assignments, and administering tests of social problem solving as needed.

Target socially valid behaviors. All too often students are taught to maintain eye contact, improve body posture, or increase question-asking without considering whether these behaviors are socially relevant. In other words, does teaching the target behavior(s) enhance the quality of a youngster's life? When behaviors are targeted for intervention based on idiosyncratic criteria or personal biases, training will be ineffective. For example, teaching a child to be assertive in a classroom setting may benefit the teacher but might not be well-received by peers at a party. Assertion, in the latter context, would not be apt to entrap naturally occurring communities of reinforcers — namely peers. Consequently, assertion would extinguish in natural environments. Socially valid behaviors can be identified by determining the relationship between behaviors observed and the outcome desired by the child (Neel & Cessna, 1990). All behaviors are purposeful and achieve a desired outcome for the child. For example, a student may become aggressive in order to gain acceptance by peers. The need to affiliate with others is quite desirable and socially valid. Therefore, teaching the student to play cooperatively may achieve the same outcome of aggression but in a more appropriate manner.

Select relevant intervention techniques. It is important to match intervention techniques with the student's particular pattern of performance deficits. Implementing techniques haphazardly runs the risk of teaching students behaviors they already possess, which in turn may decrease their performance and desire to participate with intervention (e.g., Trower, Yardley, Bryant, & Shaw, 1978). Matching interventions requires collecting the type of functional assessment information described above. Gresham and Elliott (1984) devised a system for classifying social skills problems into four general areas: skill deficits, performance deficits, self-control deficits, and self-control performance deficits. Distinctions between these four categories are based on whether or not youngsters know how to perform the skill in question and the existence of emotional arousal (e.g., anger, impulsivity) which may interfere with performance. This classification scheme provides direct implications for selecting relevant intervention techniques. For example, a student with social skills performance deficits would possess the requisite behavioral skills but fail to perform them at acceptable levels. Intervention techniques could focus on manipulating antecedents and consequences or group-oriented contingencies. A student with self-control social skills deficits who experiences anxiety that prevents her/him from acquiring specific skills would benefit from relaxation training.

Program for generalization. A common complaint voiced by practitioners is that children do not use newly acquired skills outside of training sessions. Rutherford and Nelson (1988) described four types of generalization: response maintenance, stimulus generalization, response generalization, and stimulus control. These terms reflect the concern voiced by Baer, Wolf, and Risley (1968) over two decades ago that generalization should result in behavior persisting over time, emerging in numerous contexts and settings, and extending to other related behaviors. In order to enhance the transfer and maintenance of trained skills, generalization strategies must be built into any intervention program from its inception. Stokes and Osnes (1986) described three principles of generalization programming. First, opportunities should be created for entrapment to occur. Generalization is more likely to occur if peers in the natural setting reinforce the newly acquired behaviors. Second, training should incorporate the diversity of natural settings by maintaining minimum control necessary. Third, functional mediators should be used that can serve as discriminative stimuli for engaging in the behavior. For example, having peers motion for the student to come over and join in their conversation serves as a cue to engage in the trained social skills.

Stokes and Osnes (1988) described several practical issues in generalization programming which are important considerations for consultants. First, practitioners must develop skills in applying principles of applied behavior analysis. Consultants should encourage practitioners to describe successful interventions they have implemented using principles of reinforcement and extinction. Relatedly, consultants should help practitioners identify commonalities among successful procedures for promoting generalizations that have been implemented in the past. Both consultants and practitioners should work toward generalizing their own repertoire. Adhering to principles of consultation described above that promote a collaborative relationship will help ensure that generalization programming is built into social skills training interventions from their inception. In order to train diversely, consultants should use the principle of least restrictive intervention. Intrusive interventions require being faded out to more natural procedures. Finally, assessment should be ongoing so that adjustments can be made as needed.

Conduct outcome assessment. Outcome assessment is an important component of collaborative consultation. This process should be cooperative rather than judgmental or supervisory in nature. Changes in targeted social behaviors should generalize and be maintained across time while also predicting the student's status on socially important outcomes (Gresham, 1983; Hughes & Sullivan, 1988). Outcome assessment, therefore, requires collecting information on the student's social status (e.g., sociometry) and functioning in the natural environment. Hughes and Sullivan (1988) provided several recommendations for conducting outcome assessment. First, observation systems used to measure performance in naturalistic settings should correspond to skills taught during intervention. Second, outcome measures should reflect pretreatment skills deficiencies. Third, outcome assessment should occur over an extended period of time in order to allow peers to change their perceptions of children receiving training and to ensure that entrapment becomes entrenched.

CONCLUSION

Social skills training represents an endeavor which requires special educators to provide collaborative consultation with teachers. Collaborative consultation is one possible means of addressing the interpersonal needs of students with disabilities being served in the mainstream setting. Collaborative consultation seems to be most effective when used in combination with transenvironmental programming and student-directed interventions (Fuchs et al., 1991). Several topics on which to communicate with general education teachers are described; these help reconceptualize the process of promoting students' interpersonal skills. Recommendations for special educators working collaboratively with general education teachers are presented that are general to providing consultation and specific for social skills training. Although there are a myriad of barriers to effective collaborative consultation, many can be avoided when the special educator develops rapport

and is accepted as a team member rather than being viewed as an outsider judging others' performance. Research on social skills training has provided promising results which are ideally suited to collaborative consultation. However, social skills consultation represents a new field for many who work collaboratively with general education teachers. There are few model programs, although social skills consultation reflects the general shift from a reactive to preventative approach. Given the deleterious effect social skills deficiencies have on children's adjustment, a proactive approach focusing on rearranging classroom structure seems most advantageous for fostering students' social and emotional development.

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Implementing Self-Monitoring Interventions in the Classroom: Lessons from Research

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ABSTRACT

Self-monitoring interventions have consistently demonstrated the capability of engendering positive, durable behavior changes for a wide range of mildly handicapped students. Research has shown that these interventions are both effective and practical in the classroom environment. Because self-monitoring interventions are aimed at creating self-regulated learners, and thus require little teacher time after initial implementation, they offer a powerful alternative to behavioral techniques. In this article, the author presents research-based implications for implementing self-monitoring in the classroom. First, basic principles of self-monitoring and the main types of self-monitoring interventions currently used are presented. Next, the steps in teaching self-monitoring skills to students are discussed. Finally, factors to consider in choosing a self-monitoring intervention and potential pitfalls are presented.

Throughout history the ability to self-regulate behavior has been viewed as a positive trait. We say that individuals with the ability to self-regulate possess desirable characteristics such as will power, perseverance, and resoluteness (Thoresen & Mahoney, 1974), and we celebrate the techniques that noteworthy individuals use to help themselves self-regulate their behavior. For example, Benjamin Franklin developed a list of 13 virtues that he wished to practice. He addressed each virtue in turn, regularly monitored his successes and failures in practicing each of them, and moved on to new virtues when he deemed he had attained success. Procedures that can engender self-regulation are intuitively appealing as they address a goal that is viewed as valuable — self-empowerment (Graham, Harris, & Reid, 1992).

One intervention that has demonstrated efficacy in engendering self-regulation skills for a wide range of subjects is self-monitoring (Mace & Kratochwill, 1988). Self-monitoring is defined as occurring when an individual assesses whether a targeted behavior has occurred and then records the result in some manner (Nelson, 1977; Nelson & Hayes, 1981). Self-monitoring belongs to the family of cognitive-behavioral modification (CBM) interventions (Harris, 1982) that incorporate elements of behavioral, cognitive, and developmental approaches (Harris & Pressley, 1991). In contrast to strict behavioral approaches that focus on environmental manipulation and reinforcement to effect change, CBM interventions adopt an "inside out" approach that attempts to alter behavior by changing cognitions. From this perspective if cognitions change then changes in behavior will follow. This inside out approach may be particularly well suited to mildly handicapped students who, in addition to difficulties with self-regulation, may also have an external locus of control, maladaptive attributions, and learned helplessness (Harris, 1986a; Licht, 1983), as it avoids further reinforcement of the notion that only others can control one's behavior (Graham et al., 1992). Thus in theory, self-monitoring appears to be an especially appropriate intervention for mildly handicapped students. Fortunately, it has also been shown to be effective in practice.

FOUNDATIONS OF SELF-MONITORING

Self-monitoring was originally conceived as a nonintrusive assessment tool for use in clinical settings (Mace & Kratochwill, 1988). Clients were taught to self-monitor the frequency, duration, and so forth of behaviors that were to be the target of interventions in order to collect baseline data. However, clinicians quickly noticed that self-monitoring alone had an effect on behavior. This effect termed *reactivity* quickly led to the use of self-monitoring as an intervention for a variety of behaviors such as weight loss, smoking, and marital

problems. The wide range of self-monitoring interventions points out the fact that self-monitoring interventions are not limited to overt behaviors. Although in this article the term *behavior* will be used to denote the focus of an intervention, the term encompasses a wide range that includes both overt and covert events (such as cognitions or emotions); and in fact, self-monitoring interventions are appropriate for both overt and covert behaviors. Although the exact mechanism that produces reactivity in self-monitoring is unknown, there are two established theories of which practitioners should be aware as these theoretical perspectives provide valuable guidelines when designing and implementing self-monitoring interventions. The following section describes two theoretical perspectives on self-monitoring as well as steps in instructing students in self-monitoring.

Theoretical Basis of Self-Monitoring

Two main theoretical approaches to self-monitoring have been advanced: the operant or behavioral approach (Rachlin, 1974) and the cognitive-behavioral approach (Kanfer & Karoly, 1972). Each approach postulates different mechanisms to account for reactivity. Rachlin (1974) proposed an operant approach to self-monitoring with two stages. In stage one individuals self-assess and self-record a target behavior. Both stages are viewed as cues that "remind the person of the ultimate environmental consequences that actually control response frequency" (Nelson & Hayes, 1981, p. 6). Rachlin (1974) used the example of students who self-monitored study behavior and rewarded themselves by going to the movies. He argued that if the contingencies for studying behavior (good grades, social recognition, etc.) were withdrawn, then studying behavior would cease. Thus from this perspective, reactivity results from the presence of an external reinforcer that is made more salient through the use of cues provided by self-monitoring.

In contrast, the cognitive-behavioral approach posits a three stage "feedback loop" model of self-monitoring (Kanfer, 1970, 1971, 1977; Kanfer & Karoly, 1972). Stage one consists of self-assessments and self-recording. Stage two consists of a self-evaluation based on whether the behavior(s) observed and recorded in stage one meet or fail to meet a pre-established goal or performance criterion. Stage three consists of self-reinforcement (or self-punishment) based on the results of the self-evaluation in stage two. Self-reinforcement is thought to be based on self-efficacy feedback (Kanfer & Gaelick, 1986) that occurs as a result of the self-evaluations that take place during the second stage. The self-reinforcement (or lack of) in turn affects the probability of the occurrence of the target behavior. Although the cognitive-behavioral perspective does acknowledge the importance of environment, it holds that a combination of personal, environmental, and behavioral factors create reactivity (Zimmerman, 1989).

Lessons from theory. These theoretical perspectives provide two main points of interest to practitioners. The behavioral perspective indicates that we must take care to consider the value that an individual places on the targeted behavior and/or desired outcome of the intervention. As Bandura (1977) noted, "there is no particular advantage for self-regulation of behavior that is devoid of any value." Because reactivity occurs when the behavior in question is capable of triggering self-reinforcement, if a behavior has little or no value, then reactivity is unlikely to occur. Therefore, practitioners should strive to select behaviors that have reinforcement value for students. We must also remember that the value of a behavior is not inherent in the behavior itself but is instead a function of the individual's perception of the behavior (Bandura, 1977). Thus, the same behavior could be valued quite differently by different individuals with concomitant differences in the level of self-reinforcement. For example, getting a perfect score on a spelling test could result in quite different reactions from a spelling bee champion and an underachieving student.

The cognitive-behavioral perspective points to the need to select target behaviors that are both definable and observable. Because self-reinforcement is triggered by self-efficacy feedback based on self-evaluations of whether or not the target variable occurred or met a criterion, individuals must be able to self-assess the occurrence or nonoccurrence of the behavior. Unless a behavior is readily self-assessable reactivity is unlikely to occur. Thus, target behaviors should be well defined and specific. Additionally, practitioners

should attend closely to factors that might influence self-efficacy such as prior performance (Bandura, 1977) and select tasks or behaviors that are within the ability range of the individual (Kanfer & Gaelick, 1986).

TYPES OF SELF-MONITORING INTERVENTIONS

Although self-monitoring can be used with a broad variety of behaviors, self-monitoring research to date has focused on two main areas: on-task behavior and academic responding. Separate interventions that directly address each area have been developed and thoroughly researched.

Self-Monitoring of Attention

Self-monitoring research in the classroom was initially directed at reducing disruptive behavior and began by addressing on-task behavior (Broden, Hall, & Mitts, 1971; Glynn & Thomas, 1974; Glynn, Thomas, & Shee, 1973). The interventions used required students to self-monitor whether or not they were paying attention and today are called self-monitoring of attention (SMA). SMA interventions typically cue students (using taped tones presented at random intervals) to self-assess whether they are paying attention. Students then self-record the results on tally sheets. The majority of early self-monitoring studies used this procedure. Although many early studies were methodologically flawed (Harris, 1985), the potential of self-monitoring had been demonstrated. Work with mildly handicapped students was initiated by Hallahan and his colleagues who demonstrated the efficacy and practicality of SMA with these students (Hallahan, Lloyd, Kneedler, & Marshall, 1982; Hallahan, Lloyd, Kosiewicz, Kauffman, & Graves, 1979; Hallahan, Marshall, & Lloyd, 1981; Lloyd, Bateman, Landrum, & Hallahan, 1989; Lloyd, Hallahan, Kosiewicz, & Kneedler, 1982; Rooney, Hallahan, & Lloyd, 1984; Rooney, Polloway, & Hallahan, 1985).

Self-Monitoring of Performance

In the late 1970s researchers (e.g., Holman & Baer, 1979; Paquin, 1978) investigated the effectiveness of self-monitoring academic variables. These interventions, now termed *self-monitoring of performance* (SMP), require students to self-assess some aspect of their academic performance (e.g., the number of problems completed, the number of spelling words correctly practiced, correct performance of the steps in a strategy) and self-record the results. To date, SMP interventions have largely focused on academic productivity (i.e., the amount of academic responding) and accuracy (i.e., the amount of correct responses). Harris (1986b), Lloyd et al. (1989), Reid and Harris (in press), and Roberts and Nelson (1981) have demonstrated that SMP interventions focusing on productivity and accuracy are effective with mildly handicapped groups. Although less researched, SMP interventions focusing on self-monitoring strategic performance have also demonstrated promise (Dunlap & Dunlap, 1989). There are many potential benefits of self-monitoring strategic performance including ensuring proper use of the strategy, guiding performance of the strategy, and providing the student feedback on the utility of strategy use.

IMPLEMENTING SELF-MONITORING IN THE CLASSROOM

Although there are different types of self-monitoring interventions, the steps in implementing self-monitoring interventions follow this general sequence:

1. Select target variable;
2. Collect baseline data;
3. Obtain willing cooperation;
4. Instruction in procedures:
 - a. definition of target behavior,
 - b. discrimination of target behavior,
 - c. explanation of self-monitoring procedures,
5. Independent performance; and
6. Evaluation.

These steps are based on empirically grounded procedures developed in research in self-monitoring and cognitive-behavior modification (Graham, Harris, & Sawyer, 1987; Graham et al., 1992; Hallahan, Lloyd, & Stoller, 1982; Mace & Kratochwill, 1988; Reid & Harris, 1989). When properly implemented, self-monitoring interventions are effective for many mildly handicapped students across a wide variety of behaviors. Additionally, these interventions have demonstrated sufficient social validity (e.g., Harris, 1986; Lloyd et al., 1989; Reid & Harris, in press) to justify their use in practice (Barlow, Hayes, & Nelson, 1984).

Selecting a Target Variable

The first steps in implementing self-monitoring occur before any work is done with the student. In this stage the teacher must first determine what behavior will be targeted for change and what behavior will be self-monitored. Although the behavior targeted for change and the behavior that is self-monitored are often the same, they are not necessarily *always* the same. A student might, for example, self-monitor on-task, even though the teacher is actually concerned with increasing the amount of seatwork that is completed. Choosing an appropriate target variable is critical to the success of self-monitoring interventions. When choosing a target variable, there are four factors that should be considered: specificity, observability, appropriateness, and personal match.

Specificity. Because self-monitoring requires students to self-assess the occurrence (or nonoccurrence) of a target variable, the target variable must be operationally definable. That is to say, the teacher must be able to define *exactly* what behaviors constitute the target behavior and do so in a manner which can easily be conveyed to the student. This is necessary because the self-monitoring process begins with self-assessment. Thus, students must be able to determine easily and accurately whether or not a target behavior has occurred. Avoid ill-defined behaviors such as "improving reading" or "being good"; instead use behaviors such as "number of comprehension questions answered correctly" or "being in my seat" which are easily understandable and readily assessable. The target behavior can, however, consist of a number of other behaviors as long as they are all well specified.

Observability. Because self-monitoring requires self-assessment, students must be aware of the occurrence of a target behavior. If a student engages in a behavior impulsively and/or unconsciously, they may be unaware of the occurrence of the behavior and therefore be unable to self-assess the behavior. For example, a student who impulsively talks out of turn may be unaware of the behavior. Therefore, regardless of how well the behavior was specified, lack of awareness would preclude effective self-monitoring. While self-monitoring can be effective with impulsive behaviors (e.g., McLaughlin, 1984; Piersel & Kratochwill, 1979), if reactivity does not occur it may be wise to switch to a more salient target behavior. In the hypothetical case of the student who talks out of turn the teacher might ask the student to self-monitor the number of times s/he raises her/his hand to speak as this might be more observable for the student.

Appropriateness. Assessing the appropriateness of a target behavior involves two factors — environment and risk. When selecting a target behavior it is important to be sensitive to the environment where self-monitoring will take place. Although self-monitoring has been used effectively in whole class (Prater, Joy, Chilman, Temple, & Miller, 1991), small group (Reid & Harris, in press), and individualized settings (Harris, 1986a; Lloyd et al., 1989), it is advisable to try to visualize possible problems that could arise before implementation. Procedures that cause a student to be stigmatized or are disruptive for other students are unlikely to be effective. For example, if SMA — which typically uses taped tones to cue student to self-assess — was used in a group setting and resulted in a student feeling as though s/he was singled out, it would be inappropriate. Because different target behaviors often require different self-monitoring procedures, the fit between self-monitoring procedures and academic tasks should be closely examined.

Research has shown that self-monitoring procedures can be viewed as intrusive (Lloyd et al., 1989) and that for some academic tasks different self-monitoring procedures can detract from successful performance (Reid & Harris, in press). As yet there are no

empirical principles to guide practitioners in selecting the most appropriate target behavior for any given combination of environment and task (McFall, 1977). However, one practical method might be simply to expose students to a variety of target behaviors and allow them to choose the behavior they feel is most appropriate or effective for them to self-monitor. Research has shown that — after practice in self-monitoring different target behaviors — students are capable of selecting the most effective target behavior when given a choice between several alternatives (Maag, Reid, & DiGangi, 1992).

Personal match. Assessing whether self-monitoring is appropriate for any given student involves examining the fit between the cognitive and developmental level of the student and the procedure involved in self-monitoring different target variables. Self-monitoring is not appropriate for students who are very young or are extremely immature because students must be able to grasp cognitively the connection between self-monitoring procedures and the target behavior (Graham et al., 1992). If this connection is not made in the mind of the student, then self-reinforcement will not occur and reactivity will not result. For example, imagine that a student who self-monitored the number of arithmetic problems completed and graphed the results. For self-monitoring to be effective the student must understand the meaning of the graph (i.e., be able to comprehend that the graph represented the amount of work completed) and interpret the results. Unless the student can meaningfully connect the work done with the graphic portrayal of results, reactivity (in the form of increased number of problems worked) would probably not occur.

In addition to matching procedures to the student's cognitive level, teachers should also be sensitive to developmental factors. A student's developmental level may affect the perceived value or salience of target behaviors. For example, researchers have found that as children mature their perceptions of the behaviors that constitute academic competence change (Paris & Byrnes, 1989; Paris & Newman, 1990). Younger students equate behaviors such as obedience, teacher praise, and effort with academic competence (Blumenfield, Pintrich, Meece, & Wessels, 1982; Stipek & Tannatt, 1984); in contrast, older students equate competence with work quality or comparisons with peers (Stipek & MacIver, 1989). These changes in theory should affect the perceived value and/or salience of the target behavior and thus affect reactivity. Although developmental effects on self-monitoring are only beginning to be addressed, there are suggestions of differential effectiveness of target variables across age levels effects (Maag et al., 1992).

Collecting Baseline Data

After the target behavior(s) has been selected baseline data should be gathered and recorded. Data collection should not be a strenuous or time-consuming procedure. The teacher should first define when and where the self-monitoring will take place. Next, a data collection scheme should be devised. For example, if the intervention is to be directed at out-of-seat behavior the teacher would count the number of times the student is out of her/his seat during the period of time when the intervention will occur. In the case of interventions aimed at academic goals, baseline data collection could be as simple as collecting work samples. Although it is tempting to overlook this step, there are two good reasons it should be done. First, it provides an objective benchmark to evaluate the success of the intervention. Without a baseline for comparison, it is difficult to assess accurately the effects (if any) of the intervention (Heward, 1987). Second, collecting objective data on the extent of the problem may obviate the need for an intervention! Practitioners sometimes find that the problem is not nearly as serious as they believed.

Obtaining Willing Cooperation

This stage of a self-monitoring intervention might seem strange to some, however, it is a necessary ingredient of successful self-monitoring (Hallahan & Sapona, 1983). Self-monitoring differs from more behaviorally based approaches because the student literally runs the self-monitoring intervention. The "self" is literally the active ingredient in these interventions and research has shown that student self-monitoring is superior to monitoring done by others (Hallahan, Lloyd, Kneidler, & Marshall, 1982). This, however, entails the

need for active and willing cooperation on the part of the student; the student must "buy into" the intervention. To attain cooperation, schedule a conference with the student and address the problem area(s) frankly. Point out the benefits the student would derive by improvement (e.g., staying in your seat means you don't lose recess; doing all your arithmetic problems means you'll do better on the test). Don't promise the moon; failure to deliver effects your credibility as a teacher; furthermore, students are unlikely to respond to inflated or exaggerated claims (Reid & Harris, 1989). Be optimistic but realistic; couch in terms of self-monitoring as "something that helps a lot of students like you with the same kind of problem." If students are unsure, the use of contingency contracts that call for self-monitoring to be done for a specified period of time may overcome resistance. After you have enlisted cooperation you should make clear when and where self-monitoring will be used. You are then ready to instruct the student in the actual procedures used in self-monitoring.

Instruction in Self-Monitoring Procedures

The procedures used to instruct students in self-monitoring are well delineated and will not be dealt with in great detail in this section. (For more information see Graham et al., 1992; Hallahan et al., 1979; Mace and Kratochwill, 1988, and Reid and Harris, 1989.) Some general practices should be used throughout. The instructor should be sure to be positive and enthusiastic when presenting self-monitoring procedures. During this stage of the process teachers are not only imparting skills, they are also "selling" the effectiveness of self-monitoring. Be sure to follow each step in the procedures outlined in the following sections. Although the time spent at any one step may vary widely depending on the student and the choice of target variables, it is important to go through each step in succession. Students must demonstrate mastery of each step in turn before proceeding to the next step. Although at first glance instruction in self-monitoring may appear to be time consuming and unduly laborious, this is deceptive. Students typically can learn to self-monitor quickly and easily with total training time typically well under one hour.

Defining the target behavior. Because self-monitoring begins with self-assessment students must be able to identify the target variable accurately and readily. In this stage the teacher must explain to the student exactly what behaviors (e.g., actions, thoughts, feelings) constitute the target behavior. For some types of self-monitoring interventions this may be quite simple. For example, in SMP interventions defining the target variable may involve little more than telling the student to count correct answers and providing a procedure to check work. For other types of interventions defining the target variable may be more complex. For example, in SMA interventions it is necessary to define what constitutes "paying attention." Here the teacher would present to and teach the student a list of specific behaviors that constitute paying attention such as looking at the teacher or her/his work, writing answers, listening to the teacher, or asking a question. Students must know what constitutes the target behavior before proceeding.

Discrimination of target behavior. After the student has evidenced a knowledge of the target behavior the teacher should provide a brief practice session to ascertain whether the student is able to discriminate between behaviors that constitute the target behavior and those that do not. This step is brief but important as the student must be able to discriminate between target behaviors and other behaviors if self-monitoring is to be effective. Depending upon the target variable, the teacher can first model examples and nonexamples of the target behavior and ask the student if these are or are not examples of the target behavior. Next, ask the student to model examples and nonexamples of the target behavior. This stage provides reinforcement of the knowledge of the target variable gained in the previous stage and also provides evaluative feedback for the teacher.

Explanation of self-monitoring procedures. In this stage the teacher explains where and when self-monitoring will be used and teaches the actual procedures used in self-monitoring the target variable (Reid & Harris, 1989). These steps used in self-monitoring instructions generally follow those used in cognitive strategy instruction (Graham et al., 1992; Graham et al., 1987). First, the teacher directly explains the procedures involved in

self-assessing and self-recording. Next, the teacher models proper performance while verbalizing the steps. The student is then asked to verbalize the steps as the teacher performs them. Following this, the student is asked to model and verbalize the procedures. The student should be able to perform the procedures involved in self-monitoring automatically and with facility. It is extremely important that the student attain a high degree of mastery (Mace & Kratochwill, 1988). Self-monitoring procedures should be minimally distracting for the student, therefore, a high degree of automaticity is necessary for effectiveness. After the student is able to model and verbalize the procedures correctly, a brief period of guided practice should be provided. Using guided practice at this stage is important as it provides structured experience for the student and also allows the teacher to assess mastery.

Independent Performance

After the student has demonstrated mastery of procedures, s/he is ready to use self-monitoring in the classroom. Initially it is probably wise to give a brief prompt to use the procedures and/or to check for knowledge of the target variable before the student begins self-monitoring. During the first few times a student engages in independent self-monitoring, it is important to observe her/him to be sure that procedures are used consistently and properly. If any problems are evident reteaching is necessary. Remember that if self-monitoring is to be effective the self-monitoring procedures must be used properly and consistently.

If a student appears to be having problems with some facet of self-monitoring there are several options available to the teacher. In some instances additional training may be indicated. For less serious problems, simply provide the student with prompts such as reminders of what constitutes the target behavior, or cues to self-assess or self-record may be all that is required. However, if a student consistently experiences problems it may be best to rethink whether self-monitoring is appropriate, to change the target variable, or to reteach procedures.

Evaluation

After the student has begun to self-monitor independently the teacher should continue to collect data, at least during the initial stages, in order to assess the effectiveness of the intervention. If the intervention is effective, research indicates that improvement should occur within a very short time (e.g., Harris, 1986a; Prater et al., 1991). The teacher should also conduct periodic probes to assess maintenance. In practice students have been able to maintain increased performance levels for considerable periods of time in the classroom environment (e.g., Hallahan et al., 1979; Hallahan et al., 1982; Harris, 1986a). If, however, the student's performance begins to decay, additional "booster sessions" in self-monitoring procedures may be necessary.

Summary

In this section, the author has presented guidelines for implementing self-monitoring in the classroom. Although the steps are presented in a linear fashion, it is important to realize that progress through the sequence is mastery based and the process should be considered recursive in nature (Graham et al., 1987; Harris & Pressley, 1991). When creating self-monitoring interventions certain general principles should be followed. Research indicates that for self-monitoring to be effective procedures should be (a) parsimonious, (b) minimally obtrusive or laborious, (c) appropriate to the target behavior, (d) enjoyable for the student, and (e) relevant to the student's needs (Barlow et al., 1984; Graham et al., 1992). Students must master each stage in turn before proceeding to the next. If at any stage in the instruction process a student evidences problems or indicates difficulties with earlier stages, the teacher should loop back and repeat the stage(s) as necessary. Self-monitoring instruction should not be viewed as a one-way process in which the information flow is from teacher to student (Pressley, Harris, & Marks, 1992). Instead, the student should be seen as an active collaborator in the process (Graham & Harris, 1989). Sug-

gestions or comments that the student may make pertaining to the process should be taken seriously, and when appropriate, included. Make sure that the language, concepts, cues, and procedures are appropriate for the student in terms of vocabulary level, cognitive abilities, background knowledge, and general maturity (Graham et al., 1992). Because the student is the "active ingredient" in self-monitoring, involvement *must* be at a higher level than mere mimicry of procedures. For self-monitoring to be effecting the student must be a willing and active participant (Hallahan & Sapona, 1983; Pressley et al., 1992) who is able to both understand the self-monitoring procedures and the relationship between the procedures and the desired outcomes.

TIPS FROM PRACTICE

Every teacher knows to expect the unexpected when implementing an intervention. Real world problems posed by children in the classroom have a way of upsetting the most theoretically sound appletarts. In this section, the author addresses common questions and practical problems that are likely to be encountered in practice. While the list is not intended to be exhaustive, these problems and questions are those that commonly seem to crop up in classroom practice.

Accuracy of Self-Recording

As previously noted, self-recording is an integral ingredient in self-monitoring. Many teachers are concerned about the accuracy of students' self-recording. While accuracy does seem to be a factor in reactivity of self-monitoring (Hallahan & Sapona, 1983), it does not seem to be a critical factor. Accuracy training is rarely included in SMA training as high accuracy is unnecessary for reactivity (Hallahan, Lloyd, Kauffman, & Loper, 1983) and students in SMP interventions typically evidence high degrees of accuracy without training (Harris, 1986a; Reid & Harris, in press). Although improving the accuracy of self-recording can lead to improvements in some instances (Marshall, 1983), this is not always the case (Nelson, Lipinski, & Boykin, 1978). Researchers have also found that meaningful improvements have occurred when self-recording accuracy was quite low (e.g., Broden et al., 1971; Reid & Harris, in press). Remember that the goal is improvement of behavior, not accurate self-recording. If reactivity is occurring, it may be wise to simply ignore any inaccuracies.

If reactivity has not occurred, then action is indicated. A good first step is to determine whether the student's ability to discriminate the target behavior is adequate. If this is a problem, retraining is indicated. If discrimination is adequate, the next step is to determine whether self-monitoring procedures are being used consistently and properly. For example, if a teacher were using SMA it would be a good idea to see if the student was self-recording at every cue. Sometimes students need reminders or extra cues to remind them to use self-monitoring consistently. In SMP interventions it is fairly common for some students to exhibit problems accurately counting up work or properly graphing. In situations like this, aids such as paper with numbered lines or simplified graphs can be used to overcome problems. One technique that has been used effectively in these situations is to reinforce students for properly and consistently using self-monitoring procedures. In an SMA intervention, Rooney et al. (1984) reinforced students when their number of self-recorded tallies closely matched the number of taped tones used to cue self-recording (without regard to accuracy) and found that this procedure meaningfully increased the amount of on-task behavior. Although reinforcing proper use of procedures is effective, teachers should avoid reinforcing students based on the number of self-recorded instances of the target behavior. This practice not only subverts the purpose of self-monitoring (i.e., to engender self-regulation), but more seriously, it can lead to cheating (Lloyd & Hilliard, 1989).

Is There a "Best" Target Behavior?

It is too soon to say whether any specific target behavior is the most effective in any given situation. Research in self-monitoring with mildly handicapped students has largely

focused on differences between SMA and SMP interventions. There appear to be little if any differences between the two interventions in terms of their effects on on-task behaviors (Lloyd et al., 1989; Reid & Harris, in press). However, in terms of their effects on academic performance the data are less clear. Proponents of SMA have argued that there will be little difference between the two in terms of effects on academic outcomes (e.g., Hallahan & Lloyd, 1987; Hallahan & Sapona, 1983); SMP proponents in contrast cited Trieber and Lahey's (1983) argument that monitoring academic outcomes was more likely to effect academic performance and that a focus on attention ran the risk of creating well-behaved underachievers (Snider, 1987).

Initial studies that investigated the possibility of differential efficacy between SMA and SMP on academic performance either found no differences between the two (Lloyd et al., 1989; Roberts & Nelson, 1981) or were equivocal (Harris, 1986a). However, more recent studies (Maag et al., 1992; Reid & Harris, in press) have found differences. Reid and Harris (in press) found that the procedures used in SMA were viewed as intrusive by students performing a spelling task, resulted in lower spelling test levels than the use of a strategy alone, and resulted in lower maintenance as compared to SMP. Maag et al. (1992) used a math task and found differences in favor of SMP. They also found differences between 4th graders and 6th graders in terms of the type of performance they preferred to self-monitor. The 4th graders chose to monitor productivity (i.e., the number of problems completed) while the 6th graders chose accuracy (i.e., the number of correctly worked problems). Interestingly, the condition the students chose to monitor was also the most effective in terms of academic performance. At present it appears that, for academic outcomes, SMP interventions are preferable. However, we would caution that it is not yet safe to generalize; effectiveness most likely depends on the interaction of learner, task, and self-monitoring procedures (Reid & Harris, in press). A mismatch among any of these elements may lead to disappointing results.

How Long Should Self-Monitoring Be Used?

As noted previously, self-monitoring interventions have been used effectively for prolonged periods of time in classroom environments (e.g., Harris, 1986a). There does not appear to be an upper limit on the amount of time they can be used effectively. However, because the goal of self-monitoring interventions is self-regulation, teachers may wish ultimately to have the student function at desirable levels without the use of self-monitoring procedures. For SMA interventions there is an effective procedure to "wean" students from SMA procedures (Hallahan et al., 1981). After students have effectively used self-monitoring procedures, the self-recording and cueing are successively faded. First, students are asked to self-assess without self-recording the results. After students are successful, the taped cues are eliminated and students are asked to self-assess when they think of it. Self-praise may also be used effectively during the weaning procedure (Hallahan et al., 1979). This weaning procedure is effective in maintaining gains in on-task behavior after self-monitoring procedures are completely faded.

Who Are the Best Candidates for Self-Monitoring?

When using self-monitoring for the first time, plan for success. It's a good idea *not* to pick the toughest case for your first try; instead, start with a student whose problem is mild and who should reasonably succeed. This will provide both experience and confidence. A good rule of thumb in assessing whether or not to use self-monitoring with a student is first to determine whether the student already has a potential target behavior in her/his repertoire. Remember that self-monitoring does not create new behaviors; it simply alters the frequency, intensity, duration, and so forth of existing behaviors. Self-monitoring will not be successful unless the individual already has the behavior(s) in question in her/his repertoire. For example, if the goal of a self-monitoring intervention is to increase the amount of time a student spends in her/his seat, the student would have to be able to spend at least some time in seat. A student who is totally out of control or is exhibiting severe problems is not a good candidate for self-monitoring. Remember also that while

self-monitoring can be used effectively with academic variables, self-monitoring in and of itself does not produce new learning or academic skills (Reid & Harris, 1989).

CONCLUSIONS

Self-monitoring interventions are not only effective but they provide two distinct advantages over other possible choices. First, as previously noted, self-monitoring avoids the hidden curriculum that is implicit in more behavioral approaches. In self-monitoring, students are the agents of change rather than the teacher or another adult figure. The lesson of self-monitoring is one of empowerment — students can independently effect changes in their own behavior (Graham et al., 1992).

Second, and equally important, self-monitoring offers a practical advantage over many other approaches. After the initial data collection and instruction in self-monitoring procedures, the teacher's involvement is minimal. The savings in time gained through its use can be considerable in contrast to other choices. Self-monitoring interventions do not require teachers to take the time constantly to reinforce behaviors or track points earned in token economies; instead, they are free to perform other instructional duties because in self-monitoring students literally run the intervention themselves with only minimal time requirement on the part of the teacher. Although self-monitoring interventions are powerful effective interventions, they are not a panacea. No intervention can claim to be effective for every student under any circumstances. Further, it is important for practitioners to realize that to implement effectively self-monitoring involves following both the "letter" and the "spirit" of the procedures outlined above. However, with these caveats in mind, it is the author's belief that, given the ease with which self-monitoring can be implemented in the classroom and its demonstrated track record in effecting meaningful changes, educators should strongly consider adding self-monitoring to their repertoire of interventions.

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Guidelines for the Successful Reintegration of Students with Emotional and Behavioral Disorders

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ABSTRACT

The reintegration of students with emotional and behavioral disorders is a crucial component in their special education programming. However, the reintegration of these youth into regular education settings is seldom accomplished either successfully or effectively. This article discusses several problems contributing to the low rates of successful reintegration of emotionally and behaviorally disordered students and suggests factors which may be associated with successful reintegration. Finally, systematic guidelines for conducting a successful reintegration program are presented.

The reintegration of students with disabilities into regular education settings is generally acknowledged to be one of the most crucial components in the special education process (Huntze & Werner, 1982). According to these authors, "effective reintegration is probably the weakest link in a student's individual service continuum of referral-evaluation-placement-service-reintegration" (p. 1). It may be argued that teachers and professionals serving students with emotional and behavioral disorders in particular face additional and unique challenges in providing appropriate reintegration programming.

Despite the importance of implementing appropriate reintegration practices, researchers report very little success in returning emotionally and behaviorally disordered (E/BD) students to regular education classrooms (Gable, Hendrickson, & Algozzine, 1987; Osborne, Shulte, & McKinney, 1991). In fact, it has been reported that less than 10% of students with emotional and behavioral disorders ever return permanently to the mainstream (Steinberg & Knitzer, 1992). Alarming statistics also indicate that many special education teachers infrequently attempt to reintegrate their E/BD students into mainstream settings. In a national survey of elementary and middle school teachers of students with behavioral disorders, Laycock and Tonelson (1985) reported that over two-thirds of the teachers surveyed reintegrated a total of five or fewer students during the previous 3 years. When special educators do attempt to reintegrate their students with learning and behavior problems, success rates have been reported to be as low as 12 to 33% (Gable et al., 1987; Osborne et al., 1991). And even when E/BD students remain in general education settings following reintegration attempts, very few perform at successful academic levels (Osborne et al., 1991).

Clearly, the reintegration of E/BD students may be problematic for the teachers and professionals dealing with these youth. In light of recent calls for the full integration of all students with disabilities into regular classroom settings (e.g., Reynolds, Wang, & Walberg, 1987; Sailor, 1991; Stainback & Stainback, 1984) there appears to be a critical need for the development and implementation of systematic, empirically demonstrated reintegration models which will target and attempt to alleviate some of the factors resulting in poor reintegration success rates for E/BD students (Gable et al., 1987; Laycock & Tonelson, 1985). The remainder of this article will discuss the major problems typically experienced in the reintegration of students with emotional and behavioral disorders, and those factors identified in the literature which appear to be associated with successful reintegration practices. Finally, guidelines will be presented which teachers and other professionals may follow to aid in the successful reintegration of E/BD youth.

For the purposes of this article, the term *reintegration* will be used synonymously with the terms *mainstreaming* and *integration*, and refers to the process of placing students currently receiving services in special education classrooms back into regular education settings for some or all of the school day. In addition, the authors have written this article

from the viewpoint of reintegration out of traditional self-contained special education settings for students with emotional and behavioral disorders.

PROBLEMS IN THE REINTEGRATION OF E/BD STUDENTS

Factors that influence the success or failure of reintegration generally fall into three broad categories: (a) teacher and student factors, (b) programing factors, and (c) physical/environmental factors. The components making up each of these categories will be discussed below

Teacher and Student Factors

The reasons for the poor rates of successful reintegration of E/BD youth include a variety of teacher and student factors. Perhaps foremost among these factors are the attitudes and expectations of regular education teachers toward students with emotional and behavioral disorders which may ultimately affect the teachers' willingness to receive these youth into their classrooms. A significant body of research illuminates the less than positive attitudes of many regular educators toward students with disabilities in general, and more specifically, toward students with emotional and behavioral problems (e.g., Downing, Simpson, & Miles, 1990; Fabre & Walker, 1987; Kauffman & Wong, 1991). According to Fabre and Walker (1987), "attitudinal research indicates that regular classroom teachers are frequently not receptive to the social integration of handicapped children" (p. 34). More importantly, of all special education categories, regular educators consistently rank E/BD students as those they would least prefer to have in their classrooms (Downing et al., 1990; Muscott, 1988; Salvia & Munson, 1986; Warger & Trippe, 1982). In fact, Downing et al. (1990) report that students with emotional and behavioral disorders have "the highest rejection rates of all mainstreamed students" (p. 217), perhaps supporting the contention that a troubling relationship may exist between negative teacher attitudes and negative reintegration outcomes (Callahan, 1992).

There are at least four significant reasons for the reluctance of regular education teachers to receive E/BD students into their classrooms. First, as mentioned above, there is evidence to suggest that the underlying attitudes and expectations of many regular educators toward persons with disabilities is generally negative (Downing et al., 1990; Fabre & Walker, 1987; Salvia & Munson, 1986). A related problem concerns the relatively low tolerance of regular educators for inappropriate classroom behaviors. For example, in comparison to special educators, general classroom teachers have been reported to be much less tolerant of the kinds of behavioral excesses and deficits typically demonstrated by students with emotional and behavioral disorders including behaviors such as physical and verbal aggression, noncompliance, lying, stealing, uncooperative play, hyperactivity, and high levels of anxiety (Coleman & Gilliam, 1983; Schloss, Miller, Sedlak, & White, 1983; Walker & Fabre, 1986). Regular educators and administrators have also been reported to be less tolerant of such student behaviors as not following directions or completing assignments, rationalizing inappropriate behavior, and maintaining poor personal hygiene (Schloss et al., 1983). In addition, E/BD students have been observed to require excessive amounts of teacher attention in regular classrooms, interacting with their teachers more than four times as often as their nonhandicapped peers (Slate & Saudergas, 1986). In light of these findings the negative attitudes and perceptions of regular education teachers toward youth with emotional and behavioral disorders should not be surprising.

Secondly, many regular educators believe that E/BD students will have a detrimental effect on those youth in their classrooms who do not have disabilities. However, the results of several research studies do not support this contention (Knoff, 1985; Safran & Safran, 1985; Vacc & Kirst, 1977). Early studies investigating the idea of E/BD "contagion" (Kounin, Friesen, & Norton, 1966; Saunders, 1971) concluded that deviant classroom behavior is more often a function of ineffective teacher management styles than the presence of students with emotional or behavioral disorders within the class.

The third reason often cited for the reluctance of regular educators to receive E/BD youth into their classrooms has important implications for pre- and inservice teacher train-

ing. That is, many regular educators believe they simply are not adequately prepared to teach and manage students with emotional and behavioral disorders (Kaufman, Lloyd, & McGee, 1989; Knoff, 1985; Ringlaben & Price, 1981). Finally, regular educators cite the lack of support services and technical assistance in dealing with E/BD students as a major deterrent to accepting these youth into their classrooms (Fabre & Walker, 1987; Larnivee & Cook, 1979).

An additional factor that contributes to reintegration problems is the reported widespread lack of communication and consultation between special and regular educators during the reintegration process (Hannah & Pliner, 1983; Mainzer, 1990; Osborne et al., 1991). Despite the fact that classroom teachers feel that consultation and support from special education and other resource personnel are necessary reintegration components, this support and communication are often nonexistent (White, 1979). Researchers have found that the special education teacher most often singlehandedly makes the decision to initiate reintegration, and is the sole person responsible for implementing and coordinating reintegration efforts (Semek, 1979; White, 1979). Not surprisingly, the results of mainstreaming studies indicate that reintegration is far more effective if there is consistent and persistent communication between the special and regular educators throughout the reintegration process (Harasymiw & Horne, 1976; Mainzer, 1990).

Programing Factors

Many of the reintegration problems related to specific classroom programing variables reflect a lack of planning by special education teachers for the eventuality of reintegration. In addition, special educators often fail to carry out essential steps in a comprehensive reintegration program (Gable, Laycock, Maroney, & Smith, 1991). Examples of classroom programing factors that have been demonstrated to be problematic include (a) failure to use a systematic classroom behavior management system, (b) failure to modify the E/BD student's curriculum to reflect the prospective reintegration setting, (c) failure to program for the generalization and maintenance of academic and behavioral gains, (d) failure to match student and teacher/classroom characteristics before selecting a reintegration setting, (e) failure to conduct systematic follow-up and monitoring throughout the reintegration process, and (f) failure to communicate and share knowledge with mainstream teachers in order to enhance their general understanding of both the E/BD students and the reintegration process (Callahan, 1992; Downing et al., 1990; Gable et al., 1991; Whinnery, Fuchs, & Fuchs, 1991).

An even more fundamental problem facing teachers who attempt to reintegrate students with emotional and behavioral disorders is the lack of a systematic, written plan to guide initial reintegration efforts, and the subsequent lack of ongoing evaluation and assessment throughout the reintegration process. According to Gable and Laycock (1991), "only about 50% of all school districts have a written policy governing reintegration. This absence of uniform practices invites inconsistent and arbitrary decision making and seriously impedes the mainstream process" (p. 4).

Physical/Environmental Factors

Several factors related to the school and classroom environment warrant consideration concerning their role in successful reintegration programing. Salvia and Munson (1986) investigated variables related to the educational environment and concluded that time constraints of regular educators, large class sizes, and the nonavailability of support services often negatively impact a teacher's willingness to receive students with disabilities into regular class settings. Huntze and Werner (1982) listed the physical setting (e.g., the physical layout of the school building and receiving classroom) as one of the major areas to consider when creating a match between the special education student and the regular classroom environment. If conditions exist related to physical or environmental factors which could impede successful reintegration, educators should attempt to make appropriate modifications.

FACTORS ASSOCIATED WITH SUCCESSFUL REINTEGRATION

The factors associated with successful reintegration are, for the most part, positive restatements of the major problem areas presented above. For example, researchers have reported that successful reintegration outcomes may be associated with improved teacher attitudes and tolerances, improved communication and consultation between regular and special educators, and by improved classroom programming practices.

Haring, Stern, and Cruikshank (1958) were among the first to report that "the success of any plan of integration depends largely upon how the teacher feels toward the exceptional child" (p. 1). These authors reported that improving teacher attitudes may result in improvements in instruction and teaching practices as well as improved relationships between teachers and exceptional children. In a more recent study, Dileo and Meloy (1990) demonstrated that improved awareness of similarities, increased statements of support, and improved ability to teach special education students resulted from a program focused on improving teacher attitudes and expectations. Other researchers have indicated that teacher attitudes toward reintegration can be positively modified, resulting in improved feelings, attitudes, and opinions about reintegrating students with emotional and behavioral disorders (Alexander & Strain, 1978; Harasymiw & Horne, 1976). Similarly, research suggests that attempts to improve the communication and consultation between special and regular educators may also result in successful reintegration (e.g., Hannah & Pliner, 1983; Mainzer, 1990; Osborne et al., 1991). Finally, there is a great deal of research demonstrating that improved classroom programming practices in both special and regular education classrooms are associated with successful reintegration outcomes. For example, Whinnery et al. (1991) reported that increasing regular educator knowledge and skills can lead to improved mainstreaming skills and increased acceptance of mainstreaming. Other researchers suggest that fewer reintegration problems occur when teachers in regular classroom settings incorporate appropriate methods and techniques into their teaching repertoires (Downing et al., 1990; Gropper, Kress, Hughes, & Pekich, 1968; Kauffman & Wong, 1991; Kounin et al., 1966).

GUIDELINES FOR SUCCESSFUL REINTEGRATION

The importance of successful reintegration has been empirically demonstrated (Wang, 1990). Studies investigating the efficacy of mainstreaming programs suggest that the integration of students with special needs in regular classrooms results in improved academic achievement, improved student and teacher attitudes, and improved classroom processes such as positive interactions between teachers and students, and among students (Wang & Baker cited in Wang, 1990). However, there is a lack of current literature detailing how to systematically conduct effective reintegration programs. More specifically, Reitz, Boley, and Kriegish (1988) report that "little information is available describing procedures or programs designed to facilitate the transition of behaviorally disordered students to mainstream educational programs" (p. 322).

In response to calls for models of successful reintegration for students with emotional and behavioral disorders (e.g., Gable et al., 1987; Laycock & Tonelson, 1985), several programs have been described in the recent literature. For example, George and Lewis (1991), and Fuchs, Fuchs, Fernstrom, & Hohn (1991) apply the concepts of transenvironmental programming (Anderson-Inman, 1986) to the process of reintegrating students with disabilities. Other general procedural guidelines exist within the reintegration literature (e.g., Iowa Department of Education, 1988; Jones, 1987). However, what is needed is a set of specific systematic guidelines for teachers of students with emotional and behavioral disorders to follow during the process of reintegration.

Based on a comprehensive review of the literature and a synthesis of common components of model reintegration programs, the following guidelines were developed. These guidelines consist of activities which could be used by teachers, administrators, and placement team personnel to facilitate a four-step reintegration program, and include the following major steps: (a) long-range planning and preparation, (b) immediate preparation for reintegration, (c) initiating reintegration, and (d) follow-up and evaluation (Fuchs et al.,

1991; Gable et al., 1987; Gable et al., 1991; Morgan & Jenson, 1988; Walker & Rankin, 1983). These guidelines have been arranged in outline form in order to emphasize that the activities are merely suggestions and should be modified to suit the needs of the individual teacher. In addition, no timelines have been recommended because the authors acknowledge that the activities will take varying lengths of times for each individual reintegration case.

Step One. Long-Range Planning and Preparation

1. Planning for reintegration and establishing exit criteria should begin during the special education placement process. At the initial staffing meeting:
 - A. Identify skills the new student will need for success in less restrictive settings including (a) behavioral, (b) social, and (c) academic skills;
 - B. Develop long-term goals on the Individualized Education Plan (IEP) based on skills needed in future less restrictive environments.
2. Implement behavioral, social, and academic classroom interventions that:
 - A. Focus on mainstream expectations;
 - B. Promote generalization of skills to mainstream settings.
3. Implement a systematic classroom behavior management system such as a token economy or point system.
4. Collect and maintain ongoing data on each student's behavioral, social, and academic progress within the special education classroom.
5. At subsequent IEP review meetings, focus on progress made toward expectations of mainstream settings, and update IEP goals and objectives:
 - A. Determine progress made toward long-term reintegration goals;
 - B. Determine present levels of readiness for reintegration.

Step Two. Immediate Preparation for Reintegration

1. After determining a student's readiness for reintegration, notify all persons who will be involved in the reintegration program (e.g., the student, parents, regular education teachers, and administrators) of impending reintegration plans and procedures.
2. Assess several prospective reintegration settings. Meet with regular education teachers, and conduct thorough systematic classroom inventories of:
 - A. Teacher expectations including behavioral, social, and academic expectations;
 - B. Classroom routines and procedures;
 - C. Assignment completion expectations;
 - D. Attendance and make-up work policies;
 - E. Grading policies;
 - F. Test-taking expectations;
 - G. Homework policies.
3. Match the student's behavioral, social, and academic characteristics to the most appropriate reintegration setting and teacher:
 - A. Choose and notify the prospective teacher of possible reintegration;
 - B. Schedule a meeting with the teacher to discuss the reintegration program.
4. Prepare the receiving teacher during a one-on-one meeting:
 - A. Discuss the purpose(s) of reintegration and secure the teacher's willingness to collaborate throughout the process;
 - B. Discuss the readiness of the student for initial reintegration (e.g., characteristics, strengths, areas continuing to improve);
 - C. Discuss support to be provided to the receiving teacher including (a) initial assistance (e.g., daily contact/communication, immediate classroom help, problem-solving assistance, crisis intervention), (b) follow-up and evaluation procedures, and (c) contingency plans in the event of unexpected problems.
5. Prepare the student during a one-on-one meeting:
 - A. Discuss expectations and policies of the reintegration setting, and any modifications to the current special education program which will take place;

- B. Discuss a timeline for beginning reintegration.
- 6. Modify expectations, routines, and policies in the special education class to more closely approximate those in the reintegration setting:
 - A. Modify the special education reinforcement procedures to match those of the reintegration setting;
 - B. Modify instruction and curriculum materials to match those of the reintegration setting.
- 7. Continue to document the student's readiness for reintegration into the prospective reintegration setting. Keep data on:
 - A. The student's adherence to any modified expectations, routines, and policies within the special education classroom;
 - B. The student's behavioral and social performance while using any modified reinforcement procedures within the special education classroom;
 - C. The student's academic performance while using any modified curriculum materials within the special education classroom.

Step Three. Initiating Reintegration

- 1. Prior to beginning reintegration, introduce the student to the receiving teacher. In a meeting with all persons involved in the reintegration process:
 - A. Review the expectations, routines, and policies of the reintegration setting;
 - B. Review initial assistance to be provided to the receiving teacher;
 - C. Review follow-up and evaluation procedures;
 - D. Review continued expectations for the student within the special education classroom;
 - E. Review contingency plans in the event that (a) problems arise in the reintegration setting, and (b) problems arise in the special education setting.
- 2. Begin reintegration with one class, period, or subject.

Step Four. Follow-Up and Evaluation

- 1. Maintain daily communication with the receiving teacher initially, using either personal contacts or a written reintegration progress sheet.
- 2. Collect and maintain data on the student's functioning in the reintegration setting including:
 - A. Accuracy and completeness of academic assignments;
 - B. Homework completion;
 - C. Behavioral and social performance;
 - D. Performance of all mainstream expectations, routines, and policies.
- 3. Continue to collect and maintain data on the student's behavioral, social, and academic performance in the special education classroom.
- 4. Conduct periodic meetings with all persons involved in the reintegration program to:
 - A. Review overall performance in the reintegration setting;
 - B. Review performance in the special education classroom;
 - C. Consider modifications in the student's reintegration program including increases or decreases in the amount of reintegration time.

CONCLUSIONS

For a variety of reasons the reintegration of students with emotional and behavioral disorders, despite its position of critical importance within the overall scope of special education programming, is not often successfully or effectively achieved. Many of the problems and obstacles faced by special educators in their reintegration attempts, such as negative attitudes and expectations, a lack of communication and collaboration, and demanding programming requirements, present serious challenges to the perseverance, creativity, and commitment of these teachers. However, research indicates that there are steps which may be taken to address these problems and which may be associated with increased success in the reintegration of E/BD youth.

In this article, guidelines to aid teachers and professionals in the reintegration process have been presented including activities involving both long-term and immediate planning and preparation, effective implementation of reintegration, and ongoing follow-up and evaluation. The guidelines reflect promising practices in the reintegration of students with emotional and behavioral disorders. However, further research is needed in order to investigate the effectiveness of implementing these guidelines on actual measures of reintegration success.

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Postsecondary Employment Outcomes: Suggestions for Developing a Follow-Along Study

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ABSTRACT

The study of postsecondary outcomes for students with emotional/behavioral disorders is a relatively new area of research. Using a national database, a secondary analysis of employment outcomes for students identified as having emotional/behavioral disorders was conducted. During the course of this analysis, there was an attempt to identify materials and methods that could be replicated on a smaller scale, and to determine their applicability for this specific group of students. Topics presented include (a) instrumentation, (b) the database, (c) descriptions of the student with emotional/behavioral disorders, (d) definition of employment, and (e) missing data. The article concludes with suggestions for conducting follow-along studies that can be applied by practitioners.

With the enactment of the Individuals with Disabilities Education Act (IDEA) in 1990, transition planning for community integration became mandatory for students receiving special education services. The outcome orientation of this legislation reflects an approach that has evolved during the past decade. The definition and model of transition presented by the Office of Special Education and Rehabilitation Services (OSERS, Will, 1984) is credited for focusing nationwide attention on the need for placing greater emphasis on employment outcomes in secondary special education. This model has been expanded to include, in addition to employment, outcomes related to social integration and independent living (Halpern, 1985).

A logical consequence of this focus on postschool outcomes has been the effort to determine what school experiences influence community adjustment and integration. This task has most frequently been accomplished through follow-up, and more recently, follow-along studies of postschool outcomes. The former and earliest form of outcome research is accomplished by collecting and analyzing data at some point in time after the students have left school; the follow-along research method typically utilizes multiple data collection points to track the same group of students over a determined period of time (Halpern, 1990). Although the methods used to collect information during the course of follow-up and follow-along studies (i.e., students and parents' responses to questionnaires and interviews) result in research that has inherent weaknesses, they are considered to be the most practical methods available for studying postschool outcomes of students with disabilities (Mithaug & Horiuchi, 1983). Practitioners using such qualitative research methods should recognize the limits of generalizing findings.

Studies of postschool outcomes can be developed to address questions unique to the geographic area, school district, or characteristics of population. The purpose of this article is to present suggestions for using existing follow-along research as a resource for practitioners interested in developing studies that explore employment outcomes for youth with emotional/behavioral disorders (E/BD).

Background

Reports of follow-up studies of former special education students began appearing in the literature in the early 1930s (Fairbanks, 1933). Most subsequent studies until the 1980s explored various areas of community adjustment of special education graduates with mild mental retardation (e.g., Broboff, 1955; Dinger, 1961; Titus & Travis, 1975). These follow-up studies typically utilized telephone interviews or mailed questionnaires as the instruments for collecting data from former students and/or their parents.

The results of studies of postschool adjustment that encompassed all major disability categories began to appear in the literature in the mid-1980s (e.g., Edgar, 1987; Hasazi, Gordon, & Roe, 1985; Mithaug, Horiuchi, & Fanning, 1985). These studies provided an opportunity to compare outcomes based on disability grouping. The use of multiple data collection points was demonstrated in the findings of a longitudinal or follow-along study conducted by Edgar, Levine, Levine, and Dubey (1988). These authors described the changing status of the subjects at regular intervals for a 30-month period. This type of follow-along study facilitates tracking subjects and identifying trends related to employment and residential arrangements.

Initially, students with E/BD were represented in studies but outcomes were not reported separately. During the course of later research it was noted that students with E/BD were underrepresented, and it was speculated that this might be due to a high dropout rate (Edgar, 1987; Mithaug et al., 1985). Subsequent studies involved the utilization of a larger database from which information concerning students with E/BD was extracted. Major findings included an employment rate of approximately 60% for graduates (Frank, Stillington, & Carson, 1991; Neel, Meadows, Levine, & Edgar, 1988) and 30% for dropouts (Frank et al., 1991). Neel et al. (1988) noted minimal access to vocational services (4%) and mental health services (1%).

A Nationwide Study

The National Longitudinal Transition Study of Special Education Students (NLTS), a 5-year study, was commissioned by the U.S. Department of Education and was initiated by SRI International in 1985. Information was obtained on approximately 8,000 students between the ages of 13 and 21 in the 1985-1986 school year (Wagner, Newman, & Shaver, 1989). School district information and student records were used to develop a profile of the subjects and their school experiences. The report of the analyses of the first cycle of data collection for the NLTS described the subjects of the study, 35% of whom had exited school by the 1987 survey date (Wagner et al., 1991). The report presented the results of parent interviews that were used in conjunction with the information collected from the schools. Employment, postsecondary education, postschool social activities, and independence were analyzed in terms of the influence of individual characteristics and experiences. Major findings confirmed earlier research (e.g., lower wages, males had a higher rate of employment than females, many continued to live with parents). When compared to other disability categories, students with E/BD had the highest dropout rate (50%). Those students who dropped out experienced a higher rate of unemployment than high school graduates. The results of the analysis indicated that 44.7% of the youth with E/BD who had exited school were competitively employed, and 14.8% were enrolled in postsecondary education programs. An additional substudy was conducted in 1989, and it was found that while employment rates increased over time for other disability groups, the rate of employment declined over a 4-year period for those with E/BD.

Research Guidelines

Follow-along studies can vary greatly in scope (e.g., all students, students with a specific disability) and magnitude (e.g., nationwide, local). Whether the research consists of an ambitious study of all special education students in a state or a tracking system for students exiting the local school, common elements exist. With the goal of increasing the consistency and comparability of follow-along research, guidelines for study development and methodology were offered by Halpern (1990). These guidelines include (a) the development of a model, (b) research questions that guide the development of survey questions, (c) clearly defined variables, and (d) data collection initiated when the subject is still in school and continued at regular intervals after school exit.

A CLOSER LOOK AT A NATIONAL STUDY

As the first nationwide longitudinal follow-along study of special education student outcomes, the NLTS is a resource that may be used in the development of future follow-

along research. Findings provide a point of reference for researchers and the database can be accessed to explore specific areas of interest. A secondary analysis of employment outcomes for out-of-school youth with E/BD in the NLTS resulted in observations that have implications for use of instruments and modifications of procedures (Barnes, 1992). The information presented is related to a specific outcome and disability group and is not meant to be inclusive. The analysis suggests possible strategies for utilizing existing studies and avoiding potential problems.

Instrumentation

The instruments developed for the NLTS cover a wide range of variables and are available in the data documentation manual (Valdes, 1990). This manual is a resource that can be accessed to guide the construction of future studies. These instruments include forms used to collect information from school records, a school program survey, and a parent/guardian survey in short and long form.

The Database

The data collected for the NLTS is stored in files in a widely used statistical program (SAS Institute, 1989). Information for obtaining the data file and related documentation is available from SRI International by those wishing to replicate procedures related to data collection and analysis. Statistical almanacs provide information related to specific disability categories such as E/BD (Valdes, Williamson, & Wagner, 1990).

Descriptions of the Student with E/BD

Student disability category was determined by the federal designation *seriously emotionally disturbed*; other labels referenced for inclusion were behaviorally disordered, emotionally handicapped, and emotionally disturbed. An attempt was made to determine the severity of the disability by providing respondents with subcategory identifiers of the disorder. Results of the secondary analysis of school district data indicated that only 14% of the students ($n = 263$) were classified in the subcategories *mild* (5%), *moderate* (2%), or *severe* (5%), while the remaining students were classified in the subcategory *severity unknown* (86%).

Parent interviews and school record abstracts provided an opportunity to enter further data relating to the disability of the subject. As an alternative to identifying the primary disability as E/BD, values were provided for possible responses such as neurosis, schizophrenia, hyperactivity, or motivation problems.

A variable constructed from information obtained from the parent interviews and school records identified youth who had exhibited what were labeled as *negative behaviors*. Negative behaviors included one or more of the following circumstances: (a) having been suspended or expelled from school, (b) leaving school because of behavior problems, (c) having been fired from a job, (d) living in a correctional facility, and/or (e) having been arrested. Negative behaviors were noted in 44.5% ($n = 245$) of the youth. Approximately one-half of the males and one-fourth of the females were identified as having negative behaviors.

Definition of Employment

Employment statistics may vary according to the criteria used to construct the variable. The term *competitive employment* indicates a certain level of earning based on work wages and hours. When criteria are examined separately (i.e., wages earned, hours worked), any variation will influence the stated employment outcome. For example, of the youth with E/BD identified in the secondary analysis who were employed and earning minimum wage or above ($n = 133$), 60% were working 20 hours or more weekly. If the hourly criterion is increased to a minimum of 35 hours weekly, this group is reduced to 38%.

Missing Data

The inability to contact subjects in the original sample of 12,000 youth was noted as a problem in the NLTS report. Due to unavailable addresses or phone numbers, only about 8,000 (or three-fourths of the original sample) were finally included. Additional loss of subjects occurred during the course of a longitudinal study due to various circumstances such as moving without leaving a forwarding address.

Missing data that occur as a result of incomplete data collection may compromise the accuracy of research findings. Information that is not available in records or missing responses to survey questions illustrate this problem. Anticipating and developing strategies to deal with missing data (e.g., determine a minimum response rate for each item) can improve the reliability of findings and avoid potential frustration for the researcher.

DEVELOPING FOLLOW-ALONG STUDIES

The following suggestions have been developed based on an analysis and application of the NLTS instruments, methods, and findings related to students with E/BD who have left school. Some of the suggestions are generic in their application, while others are specific to students with E/BD.

Save time, money, and energy. Utilize existing studies in the development of instruments and methods. Determine what information is wanted and modify the instruments accordingly.

Tailor the model. Identify information that is specific to the students to be surveyed. For youth with E/BD, issues such as dropping out of school, arrest rate, and access to community-based mental health services may be areas of focus within the model.

Match data management to use. Determine the data management system to be used based on the information to be gathered and the statistical analyses planned. Standard computer programs are likely to meet the need of those who are seeking basic output such as percentages or averages. More complex statistical procedures will require the use of specialized statistical programs such as the SAS used in the NLTS.

Describe the population. Identify important descriptive information related to the disability and determine the method for collecting that information. For example, an instrument such as a behavior rating scale might be used with students with E/BD in order to differentiate those considered aggressive/acting out from students identified as withdrawn.

Gather school information early. Students with E/BD who are 16 years old drop out of school at a rate of 73% (U.S. Department of Education, 1992). Follow-along studies should be initiated no later than junior high school. By the age of 16, many students with E/BD will have left school and the quality and type of information needed is likely to be inaccessible.

Extend the study. Students who have been diagnosed as E/BD and who leave school have a tendency to change jobs frequently. The results of the NLTS indicate that, contrary to expectations, the unemployment rate for this group increases over time. More information is needed about the outcomes for this population over an extended period of time after leaving school.

Devise tracking strategies. Tracking students who have left school can be a frustrating task. It may be necessary to limit the subjects in the study based on personnel capabilities. Strategies for staying in touch with the students are especially important for areas that have a very mobile population. For example, data collection conducted every two years may be supplemented by annual written or telephone contacts.

Be persistent in collecting data. Identify the people who will be supplying the data needed and the potential roadblocks that might be encountered. Develop a training program for those responsible for data collection. Be realistic in the time devoted to collecting data; repeated contacts will probably be needed.

Describe outcomes precisely. Collect and present information about outcomes such as employment that communicates the status of the subjects in a variety of ways. For example, in addition to collecting data about wages and hours employed, include questions related to benefits, job satisfaction, and acceptance by co-workers.

CONCLUSION

The goal of the follow-along research discussed is to determine postschool outcomes for students with emotional/behavioral disorders and to identify school experiences that appear to influence community integration. It is suggested that existing follow-along methods and instruments be adapted for use in studies at the local level.

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Re-ED and Hobbs' Twelve Principles: Twenty-Five Years Later

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ABSTRACT

Ecological approaches to serving children and youth with emotional and behavioral disorders are associated historically and conceptually with the work and philosophy of Nicholas Hobbs and Project Re-ED. In the 25 years since Cumberland House and the Wright School were established, the Re-ED model and the 12 principles proposed by Hobbs continue to be employed in the treatment of emotionally and behaviorally disordered children and adolescents. This article examines the Re-ED model and the 12 principles considered essential to its success in light of expert opinion, empirical research, and clinical practice common to the 1990s.

For over 25 years the best known translation of the ecological perspective of behavioral and emotional disorders (EBD) into practice has been Project Re-ED developed by Nicholas Hobbs (Hobbs, 1973). Re-ED refers to the "re-education of emotionally disturbed children" and was created as an alternative to the prevailing psychoanalytic perspective of the time. Indeed, Hobbs purported that treatment based on traditional methods could have an adverse effect on students (Hewett, 1983). Motivation for establishing Project Re-ED also was anchored to the goal of minimizing service delivery problems associated with limited professional and financial resources. The Re-ED model emphasized mental health rather than mental illness, teaching rather than treatment, learning rather than personality reorganization, the present rather than the past, and the operation of the total system rather than individual intrapsychic processes (Newman, 1992). In the early 1960s, the Re-ED model came to fruition with the establishment of Cumberland House in Nashville, Tennessee, and the Wright School in Durham, North Carolina. Since that time, Re-ED schools and ecological approaches to treating students with EBD have emerged across the country (Hewett, 1983) or been incorporated into existing treatment programs. Although aspects and interpretations of the Re-ED model vary, the important central roles of the teacher-counselor and liaison teacher-counselor have been retained or enhanced.

Hobbs and his colleagues had envisioned a program in which qualified teacher-counselors functioned as the primary treatment agents, professionals who would exert through daily contact a powerful influence on each student's emotional adjustment and academic achievement. The teacher-counselor's job was to teach academics and provide counseling. The liaison teacher-counselor's responsibility was to involve the family and the community in the treatment process. The liaison teacher-counselor facilitated communication among members of the student's ecology (e.g., school, home, neighborhood, and the greater community) and attempted to mobilize resources in those ecosystems.

Qualified teacher-counselors and liaison teacher-counselors were individuals who could teach and work effectively in the classroom and community. Equally important, they were individuals who believed in and could operationalize the 12 principles Hobbs espoused to guide professional behavior and daily interactions with students. Hobbs' 12 principles, paraphrased in Table 1, are viewed as related directly to the success Project Re-ED has experienced (Dokecki, 1985).

Please address correspondence pertaining to this article to the second author.

TABLE 1
The Twelve Principles of Project Re-ED

Number	Principle
1	Life is to be lived now, not in the past, and lived in the future only as a present challenge.
2	Trust between the child and adult is essential; it is the glue that holds teaching and learning together; it is the beginning point of re-education.
3	Competence makes a difference; children and adolescents should be helped to be good at something, especially at school work.
4	Time is an ally. Childhood and adolescence are periods of development when life has a tremendous forward thrust.
5	Self-control can be taught and children and adolescents helped to manage their own behavior; symptoms can and should be controlled.
6	The cognitive competence of children and adolescents can be enhanced. Intelligence can be taught.
7	Feelings should be nurtured, shared, controlled when necessary, expressed, and explored with trusted others.
8	The group is important to young people; it can be a major source of instruction.
9	Ceremony and ritual give order, stability, and confidence to troubled children and adolescents.
10	The body is an armature to the self, the physical self around which the psychological self is constructed.
11	Communities are important for children and adolescents; the benefits of community must be experienced and learned.
12	A child should know joy each day and look forward to some joyous event for the morrow.

The remainder of this article presents an update on Project Re-ED as a program model. Discussion of each of Hobbs' 12 principles in relation to the education and treatment of children and youth with EBD constitutes the focal point. Recommendations for future research related to Re-ED and the 12 principles are presented.

Re-ED — An Evolving Program Model

Project Re-ED was established as a short-term residential program for children with EBD (i.e., emotionally disturbed) and marked a significant shift away from traditional psychoanalytic treatment programs by emphasizing mental health, education, and the current life circumstances of the child. In the past 25 years many changes have occurred in society and in the treatment of children with EBD. Today, communities, families, and the children served are substantially different from the 1960s when a majority of the children were voluntary admissions from intact, middle to upper middle class families. Now, most Re-ED students are referred by the court system and come from single parent or nontraditional families of low socioeconomic status. The type and severity of the behaviors seen in the 1990s stand in stark contrast to those of the early 1960s. Presently, Re-ED students are typically children and youth with chronic and severe behavioral and emotional disorders (i.e., serious antisocial or delinquent behavior).

Prior to discussion of Hobbs' 12 principles, it is essential to point out that the Re-ED model itself has evolved across time. Although Hobbs (1975) declared that the mission of Re-ED was to make the total system work, not to merely change the student, this ecological orientation was not clearly articulated in early Re-ED programs. Even as late as the

1970s, assessment of the *match* between the student and the student's ecology, had not yet emerged to guide treatment. For instance, a common goal in Project Re-ED was to take students into the community and teach them functional life skills. This practice expanded the treatment milieu beyond the walls of Re-ED, yet remained focused on the student side of the student-environment mismatch instead of the student-environment interface.

Although attempts to change ecological systems to fit to students' needs were limited in the early years of Re-ED, the role of the liaison teacher-counselor as a crucial change agent permeated Re-ED programs. Through the work of the liaison teacher-counselor, the assumption that the child was "an inseparable part" (Hobbs, 1966) of her/his ecological unit was strengthened. Testimony to the expansion of the ecological perspective within Re-ED can be measured indirectly through such developments as staffing patterns which showed a four-fold decrease in the student to liaison teacher-counselor ratio. Nonetheless, assessing the effectiveness of ecological intervention within Re-ED remains a difficult, elusive task (Lewis, 1988).

Student Outcomes and Project Re-ED

A major evaluation of the Re-ED model was undertaken 6 years after its inception by a panel of experts who concluded that the Re-ED model was "a conceptually sound, economically feasible, and effective approach to helping 'children'" (Bower, Lourie, Strother, & Sutherland, 1969, p. 23). This third party evaluation team reported that Re-ED had developed concepts applicable to other educational and mental health programs and proclaimed that Re-ED had passed the test of professional, public, and legislative scrutiny.

Laura Weinstein (1974) conducted one of the earliest and most comprehensive examinations of child change data in a follow-up study of Cumberland House students (i.e., elementary-aged students). She found that at the time of discharge and on follow-up, results favored former Re-ED students over untreated students (i.e., students who had not participated in Re-ED and/or received other services) on almost all measures (e.g., self-concept, impulsivity, self-control, school achievement). School achievement was determined to be a good predictor of later success. Children whose performance was adequate on admission or who made significant school improvement while enrolled in Re-ED were more likely to make a good long-term adjustment. On the other hand, although adults rated Re-ED students as substantially improved, sociometric ratings of peers before and after enrollment did not change significantly.

More recently, studies of students at Cumberland House and Crocket Academy (i.e., middle and high school students; Lewis, 1982, 1984, 1988) appear to support Weinstein's results. Although initial investigations failed to find any correspondence between the amount of improvement during treatment and children's later adjustment, a few studies and clinical data seemed to indicate that there was a relationship between a subject's adjustment and a supportive ecology. Unfortunately, no early reports specifically indicated how, to what degree, or how often the Re-ED treatment program had attempted to influence the student's ecology. These recent publications by Lewis lend credence to the assertion that ecological change during treatment, along with improvement in the child, is essential to continued adjustment after discharge.

An example of a study with a narrower focus was conducted by Lochman, Bennett, and Summers (1988) who examined the effect of a Re-ED program on highly aggressive adolescents. After an average of 18 months' enrollment, the adolescents improved significantly, showing decreased hostility, anger, and arousal, and increased feelings of control over their environment and improved academics.

In all, studies spanning the past two decades appear to support the clinical viability of the Re-ED model and the importance of ecological change to positive outcomes for students. How these promising results relate to the 12 principles Hobbs delineated for guiding Re-ED staff behavior has not been investigated systematically. Because of the importance that Hobbs placed on the 12 principles, a closer examination of each principle (see Table 1) follows.

Principle 1: Life is to be lived now. Project Re-ED intervention approaches are based on the contention that opportunities for learning, facing challenges, and garnering positive experiences occur in the present, and that no special hour can be reserved for "therapy." Consequently, treatment was viewed as an ongoing process in which every hour of every day was important to the child's future. Today, numerous therapeutic approaches emphasize the "here and now" (versus past experiences). One model of treatment for emotional disorders and mental health which can be associated with the principle that life is to be lived moment by moment is Glasser's Reality Therapy. In Glasser's (1966) approach, treatment of psychiatric disorders concentrates on what is occurring in the life of the person at the present moment. The role of the therapist (or teacher) is to help the client (e.g., student) understand what is happening in the here and now and how to make choices that will lead to a more satisfying life. Glasser views students as competent individuals who have the ability to make good or bad behavioral choices. From Glasser's perspective, it is the educator's role to encourage students to talk and reflect, to clarify values, to participate in the decision-making process, and to create school experiences which have immediate relevancy for the child.

Life space interviews (LSI; Redl, 1959) and life space intervention (Wood & Long, 1991) — an expansion of the LSI — also focus on the present by providing on-the-spot emotional support to mediate crisis situations and to prepare the student for future challenges. In such situations, the teacher uses a present crisis to assist the student in better understanding her/his emotional state, motivations, and the conditions which led to the unacceptable outcome. Together, possible alternative responses for future situations are generated. Similarly, ecobehavioral (Greenwood & Carta, 1987; Hendrickson, 1992) and behavioral analytic (Sulzer-Azaroff & Mayer, 1991) perspectives stress present conditions and their relation to one another. However, these latter approaches emphasize observable behaviors and events (versus feelings, thoughts, and inner states) in the treatment of emotional and behavioral disorders.

Principle 2: Trust between the child and adult is essential. Students in Re-ED programs usually have experienced substantial trauma resulting in the belief that adults are deceptive, unpredictable, punishing, and nonloving. Hobbs (1982) perceived Re-ED staff to be persons who were tolerant, caring, warm, strong, and determined. The teacher-counselor, especially, was an individual whose role was to provide support, understanding, nurturing, and predictability. Staff were expected to maintain objectivity to cope with aggressive behavior, for example, and not fall prey to manipulative behavior. In short, establishing trust between Re-ED staff and the children was a key to the re-education process. Hobbs (1982) portrayed trust as the glue that holds teaching and learning together.

Today, discussion of trust and a child's development continues to pervade the professional literature, especially in relation to children and youth considered at-risk for school dropout and poor adult outcomes (e.g., Brendtro, Brokenleg, & Van Bockern, 1990). Kutnick and Bress (1982) claim that without trust a child does not have the ability to learn from an adult. Kinard (1980) contends, after assessing abused and nonabused children, that establishing trust is one of the earliest of developmental tasks. Bryngelson (1992) describes the "orchestrated classroom" for students with emotional and/or behavioral disorders as one which revolves around the teacher-student relationship and the establishment of trust.

The literature is replete with descriptions of abuses of children's trust by adults and the subsequent travails of these children as they move through childhood, adolescence, and adulthood (e.g., Casey, 1991). Satanic cults allegedly recognize the importance of trust to the young child and work actively and systematically to destroy the child's ability to trust (Lamkin, 1990). One cult standard is said to employ parents and caregivers as agents of mental torment, physical torture, and general unpredictability. Their victims display a severely impaired ability to bond emotionally. In addition, these individuals often exhibit little or no confidence in their own perceptions and cognitions, having learned that nothing can be trusted (Lamkin, 1990).

Principle 3: Competence makes a difference. By definition, children with emotional and behavioral disorders have distinguished themselves in ways that appear disturbed or are disturbing (Algozzine, 1977). Students with EBD often perceive themselves negatively, are less popular, less socially adept, less academically competent than age peers (Gable, Hendrickson, & Rutherford, 1991), and show a less successful adjustment to adult life (Frank, Sitlington, & Carson, 1991) than students who have not been identified as emotionally and behaviorally disordered. Re-ED programs traditionally have operationalized the concept of competence by seeking opportunities for every student to learn to be good at something. In Project Re-ED a special effort is made to develop the academic competence of each student (Hobbs, 1966).

The development of competence is supported in research which documents a correlation between academic competence and behavior problems (Margalit, 1989). Blech, Tinley, Carella, and McEnroe (1985) report a positive relationship between academic competence and peer ratings of social competence. According to Margalit (1989), students with low academic competence tend to exhibit behavioral problems. Other researchers report a positive correlation between IQ and social competence (Moskowitz & Schwartzman, 1989). Finally, research suggests that a correlation exists between low self-esteem and decreased ability (Koenig, 1988), and that increased competence in "rational thinking" skills can have a positive effect on the self-concepts of adolescents with low self-esteem.

Principle 4: Time is an ally. According to Hobbs (1966), long-term psychiatric hospitalization may have an adverse affect on children. Compared to other programs of the 1960s-1970s, Re-ED was a relatively short-term residential program. Numerous assumptions underpin the Re-ED principle of "time is an ally" including the beliefs that (a) children and adolescents are in a developmental period characterized by rapid change, (b) short-term treatment avoids estranging students from their natural ecosystems, and (c) short-term intervention reduces the development of overdependence on Re-ED staff.

These tenants in fact are supported in the literature. Clinicians and researchers today are well aware of the wide range of behaviors all children display, and that most children at times exhibit behavior that could be considered disordered, delinquent, or maladjusted as part of the normal developmental process (Kauffman, 1993). Lochman et al (1988) briefly review research which indicates that children with chronic and severe emotional and behavioral disorders have the poorest outcomes following hospitalization, and among students with conduct disorders, inpatient treatment has been least effective with those who display more serious and more frequent antisocial behaviors. Riessman, Rabkin, and Struening (1977) document brief hospitalization to be as effective in relieving psychotic behaviors as more lengthy treatment. The impact of life events on the psychological functioning of children and youth (see Conger, 1991) is a burgeoning area of research and reveals the potential detrimental effect of negative life experiences (e.g., changing schools, removing from home, death of a parent or pet) on child adjustment. Finally, as greater emphasis is placed on serving children in the least restrictive environment (LRE; see *Exceptional Children*, 1990), strategies to reduce referral rates and length of treatment in self-contained, out-of-district and/or residential units are being developed in response to increased pressures to serve students in the LRE.

Principle 5: Self-control can be taught and children and adolescents helped to manage their behaviors. Self-control and taking responsibility for one's behavior requires awareness of the behavior, its consequences, and the development of skills to choose alternative behaviors. In Re-ED programs, lack of self-control is viewed as a skill deficit and is taught directly through strategies such as modeling, role-play, and self-monitoring. Students are re-educated to manage their behavior through a process of unlearning habits that have led to rejection by peers, adults, and the community in general. Research on self-management strategies (e.g., self-monitoring, self-evaluation, self-reinforcement, self-instruction) supports the Re-ED approach. Self-management approaches have been applied successfully to a wide range of students with disabilities and have been documented to improve academic skills (e.g., Prater, Hogan, & Miller, 1992) and social skills (see Rutherford, Chipman, DiGangi, & Anderson, 1992), and to reduce hyperactivity

(Barkley, Copeland, & Sivage, 1980) and aggressive behavior (e.g., Lovitt, 1973). Besides reduction of disruptive behavior, self-control training has been effective in reducing anxiety, which in some situations can be the cause of disruptive behavior in children and adolescents (Deffenbacher, Michaels, Michaels, & Daley, 1980). Feidler, Marriot, and Iwata (1984) report anger control training with delinquent adolescents resulted in increased self-control and problem-solving behavior, and decreased disruptive behavior and severe aggression. In all, a large body of research lends credence to the merit of teaching self-control and self-management strategies to students with emotional, behavioral, and/or learning difficulties.

Principle 6: Cognitive competence. In the Re-ED model, intelligence is perceived as a malleable capacity, not a fixed state. A child's cognitive competence — ability to understand and respond to the different academic and social demands of her/his ecology — is thought to be improved through practice, and especially through practice problem solving. In Re-ED programs, problem-solving skills are taught and reinforced by discussing and evaluating ongoing events, taking control over events in one's life, and problem-solving training (Hobbs, 1982). Problem solving is taught formally and incidentally as events occur throughout the youngster's day.

Related to the Re-ED belief in developing cognitive competence is the definition of *intelligence*. Generally speaking, students with emotional problems test in the low average range on standardized intelligence tests (Kauffman, 1993), a factor which may set an expectation for low performance by teachers and other service providers. In the last decade, prevailing sentiment regarding intelligence as a global fixed factor has been vigorously attacked (e.g., Armstrong, 1987, 1993; Gardner, 1983). Many contemporary educators and clinicians take the stance that there are multiple intelligences and that the role of the educator, clinician, and parent is to identify and develop the different intelligences and learning styles of the child. The construct of multiple intelligences which are dynamic and open to development is consistent with the Re-ED philosophy of building competence in every child. For example according to Armstrong (1993), there are seven kinds of *smart* — word smart, picture smart, music smart, body smart, logic smart, people smart, and self smart. People smart and self smart are two types of intelligences typically underdeveloped in students with EBD. Re-ED programs work daily on exploring and practicing people skills and in developing the child's sense of self.

Center (1989) contends that adaptation and problem solving are related to a student's interaction skills, communication skills, and cooperation and sharing skills. Toro, Weissberg, Guara, and Liebenstein (1990) report that students who are unable to generate alternative solutions to various problems are judged to have more difficulty in the classroom and less interpersonal and social competence. Self-esteem, academic ability, and placement in special education appear to be related. Choran and Morrison (1984) note that poor academic ability is predictive of low self-esteem, and Fagan (1980) finds that placement in a special education class lowers self-esteem. Finally, a substantial body of research supports the proposition that academic and social problem-solving skills can be taught to schooled children in a step-by-step manner (e.g., Goldstein, 1988), which in turn should positively affect student self-esteem, confidence, and adaptability. This research and recent theories of intelligence blend well with Hobb's unyielding belief in the child's potential to develop, grow, and become competent.

Principle 7: Feelings should be nurtured, shared, controlled when necessary, expressed, and explored with trusted others. The Re-Ed philosophy encourages and enables the child to express her/his feelings (Hobbs, 1966). Feelings may be expressed conversationally but also through creative activities that form the daily routine of Re-ED programs. The expression of positive feelings is equally as important as the expression of other feelings.

Various authorities concur with Hobbs regarding the importance of the child feeling that s/he is accepted. Acceptance is demonstrated by allowing and encouraging appropriate expression of feelings without criticism. Chervin (1986), Center (1989), and others believe classroom curricula should address the social-affective development of the child.

Chervin (1986) and Deering (1986) suggest that through acknowledgment and expression of feelings, self-esteem can be improved, freedom to learn established, and academic and social growth promoted.

In addition, adolescence is a developmental period when young people are experimenting in the search for and construction of their own self-identity (Conger, 1991). They may be especially sensitive to criticism and need the unconditional support of adults and peers in identifying and expressing their strong and oftentimes conflicting feelings.

Deering (1986) documents the positive effects of the expression of feelings in three emotionally inhibited children ages 7-15. The expression of feelings was accomplished through an intervention program that contained six components: (a) keeping the therapeutic environment safe; (b) developing a strong alliance; (c) progressing slowly in therapy; (d) using active, structured play techniques; (e) using indirect methods of eliciting feelings; and (f) modeling appropriate affect.

Principle 8. The group is important to young people. Re-ED programs are designed for each child to become an active member of the group. The group process is used to make decisions that affect individuals as well as the entire group. Hobbs (1966) believed that the group allows members to identify with others and develop both a sense of belonging and a sense of control. Group participation requires interpersonal interaction, giving and receiving information, and facilitates the development of mutual understanding and trust. In Project Re-ED it is recognized that the manner in which the group as a whole functions can affect the individual's behavior and feelings (Newman, 1992). By teaching the group to behave more acceptably in relation to cultural norms and societal expectations, the likelihood of individuals acting in disturbed or disturbing ways is reduced. Furthermore, by sharing experiences, sorrows and joys, successes and failures in a group context, each student's sense of belonging is reinforced as well as her/his ability to empathize with the feelings of others.

Numerous studies examine the utility of the group process in modifying inappropriate behavior. Kauffman, Pullen, and Akers (1986) demonstrate the successful use of group-oriented contingencies to encourage achievement and appropriate behavior in a regular education setting. In a study by Critchley (1982), group therapy with dysfunctional, abused children led to positive changes in the children's play and interactions with peers. McKibben and King (1983) report that when students with behavioral problems are placed in small groups and instructed to complete a gross motor activity together, the subsequent group interaction appears to facilitate understanding of self and others. An increase in appropriate interactions, impulse control, and positive expression of feelings emerge following treatment.

Some investigators have examined the role of the group more directly. Sandler, Arnold, Gable, and Strain (1987) employed group pressure to modify inappropriate verbal and nonverbal behavior of students with behavioral disorders in a public school setting. In this study classmates asked the targeted students a series of questions dealing with (a) the disruptive behavior, (b) whether the student realized that the behavior was a problem, and (c) what specific changes in behavior might rectify the situation. Peer pressure structured in this manner appeared to be effective in reducing target and nontarget problem classroom behaviors.

Reitz, Gable, and Trout (1984) followed Hobbs' guidelines with regard to the group process and goal-setting by students; that is, self-selected goals should be (a) specific statements of overt behavior, (b) appropriate to the individual student, (c) positively stated, and (d) limited in number. These authors focused on teaching self-control through a group process similar to the Re-ED "pow-wow." Anecdotal and clinical data collected by Reitz et al. indicated that the use of group contingencies is an important aspect of treatment in relation to planning, evaluation, and problem-solving sessions. Kerr, Strain, and Ragland (1982) combined group goal-setting and feedback within a loosely organized pow wow to intervene in the aggressive behavior of students with EBD on the playground. Results showed a rapid and dramatic increase in cooperative play and a substantial drop in aggression.

Principle 9: Ceremony and ritual give order, stability, and confidence to troubled children and adolescents. Re-ED programs typically serve youngsters from environments characterized as unpredictable, with the consequences of behavior, affection of parents, and the meeting of survival needs varying dramatically from day to day. This ecological instability may result in confusion about behavioral expectations and little self-confidence in the child. Ritual and ceremony give stability to daily life and establish the framework for intermediate and long-term expectations. The use of group names, group meetings, and a levels management system which reflects set responsibilities, privileges, and consequences for various behaviors may be viewed as falling under the construct of ritual and ceremony. The assumption is that when events become regular and predictable (i.e., ritualized), the opportunity for freedom of thought and expression of feelings increases as well as a sense of belonging and expectation.

Ceremony and ritual, d'Aquili (1985) believes, create a feeling of oneness within a group and the feeling of being special, both of which produce a unifying effect. Consequently, the individual develops a sense of having a role in the group and being responsible to the group. Because ceremony and ritual aid in bringing about unity, d'Aquili feels that intragroup aggression decreases. Rosenthal and Marshall (1988) believe that rituals and ceremony add continuity in life, which helps individuals (and groups) to deal with change more effectively. Brentro and his colleagues (1990) point out the importance of belonging in Native American cultures and suggest that rituals and ceremony are one key to mental health and community membership.

Principle 10: The body is the armature of the self. Within Re-ED programs an individual's understanding and development of her/his physical capabilities is held to be important for establishing self-esteem and a willingness to meet the daily challenges of life with a positive yet realistic attitude. By presenting students with physically challenging and adventurous activities which require endurance, strength, coordination, and mental concentration (e.g., camping in wilderness settings), Re-ED programs offer students opportunities to meet physical challenges and come to understand themselves better. Mutual interdependence required for some achievements during games, daily chores, and meeting the rigors of outdoor life is believed to foster understanding and trust of others — peers and adults.

Sachs and Miller (1992) report the results of a wilderness experience (e.g., hiking, spelunking, and continuous exposure to the elements) on the social interactions and expectations of adolescents with behavioral disorders in their classrooms subsequent to the intervention. Their study is exceptional in that it is one of few investigations of recreation and/or wilderness programs which employed a control group and use multi-modal assessment. These investigators were especially interested in the effect of camping activities on the aggressive and cooperative behaviors of student participants. Results suggest that cooperative behaviors were affected positively; however, aggression did not appear to be reduced subsequent to a wilderness experience.

Principle 11: Communities are important for children and adolescents. In Re-ED, teaching children and youth the benefits of the community and membership in and acceptance by the community are considered important goals. According to Hobbs (1967), it is critical for children with emotional disorders to become bona fide members of the community since the majority of Re-ED students usually are alienated from their communities in any number of ways. The student will return to the community, and unless the student is able to function more successfully and/or the community's expectations of her/him are modified, there will be an ecological mismatch leading to rejection and possible ejection of the child from the community. In operationalizing the importance of communities, Re-ED programs emphasize firsthand experience and learning through community involvement. Community awareness is the first step and follows the pattern of activities common to most schools (e.g., field trips to public agencies, private organizations, historical sites, libraries, and businesses; guest speakers and visitors from the community). In the process of becoming involved in the community, children learn appropriate social behaviors and the community learns to assume responsibility for all of its members (Hobbs, 1982).

Van Til (1983) emphasized that social skills may be learned better in the community than in classroom settings. When learning takes place in the student's natural environment, adaptive alternatives for handling problem situations can be taught on-the-spot. Wiggins and Behrmann (1988) point out the importance of community-based education for students with disabilities given that these students do not generalize skills well to non-treatment settings. With the community as the classroom and the treatment setting, students directly and contextually experience how they will need to handle themselves on a posttreatment basis.

Principle 12: A child should know joy each day. According to Glasser (1969), emotionally disturbed children usually have experienced chronic frustration and failure and these experiences span the family, community, and school ecologies. Children with emotional and behavioral disorders have learned to anticipate little success or happiness. Hobbs' (1982) points out that a wealth of information is available on the negative effects of anxiety, guilt, and dread, while little is known of the positive effects of joyous experiences. Re-ED programs stress the student's overall well-being with each day designed to hold anticipation of a joyous experience. When a child feels joy, it is hypothesized, little energy is left for engaging in disruptive or destructive behaviors. For Hobbs, the key to creating joy in the child's day lays in the selection of workers who are well educated, who recognize the usefulness of today and the promise of tomorrow, and have the intrapersonal resources for nourishing and restoring their own life. For Hobbs, children could restore purpose to their lives through engaging in activities of "just manageable difficulty" so a zest for life will develop (Hobbs, 1973).

CONCLUSION

Since the inception of Project Re-ED in the early 1960s, numerous ecologically based programs have been initiated around the country for children and adolescents with EBD. As previously stated, the ecological approach provides an alternative model for treating individuals with emotional problems by taking into consideration the individual's total ecosystem (Hobbs, 1982). Accumulated evidence suggests that various Re-ED programs have produced positive results for students with EBD including improved self-esteem, enhanced academic and social outcomes, and improved community adjustment and posttreatment adaptation. A variety of clinical and empirical studies lends support to the conclusion that the Re-ED model has been effective in meeting its mission and that its effectiveness is linked in large measure to the 12 philosophical principles promulgated by Nicholas Hobbs. Although these principles have strong intuitive appeal, to date they have garnered only varying amounts of clinical and empirical support. The relative value of any one principle has not been experimentally examined nor have ecological factors been systematically assessed. Although not all of these principles can be subjected equally to empirical validation, over a quarter of a century has passed since the emergence of the Re-ED model, and if these and other programs are to better serve the student with EBD, greater scientific rigor is needed to separate myth from reality.

As we enter the 1990s, it is clear that research is needed to provide documentation of the soundness of Hobbs' 12 principles; however, it is noteworthy that a great deal of work has been accomplished in relation to principles 1 (live in today), 3 (competence), 5 (self-control), 6 (intelligence — cognitive competence), and 8 (the group). Principles 2 (trust), 4 (time), 7 (feelings), 9 (ceremony), 10 (body), 11 (community), and 12 (joy) are more philosophical and to varying degrees less amenable to experimental control. Nonetheless, principle 11, the importance of community (including the family, neighborhood, and school), a principle inextricable from an ecological orientation, deserves and indeed requires systematic scrutiny if the merit of ecological treatment is to be maximized. More specifically, documentation of the types, intensity, and duration of community interventions and accommodations is necessary to assess the degree to which student outcomes are related to ecological factors. Examination and comparison of different strategies for involving students in community, service-oriented projects, for example, might be one line of fruitful research.

Finally, one of the most compelling arguments for reexamining the Re-ED model, the 12 principles, and the ecological perspective originates with Steinberg and Knitzer (1992) who summarized the results of a nationwide study of public education for students with EBD from which it was concluded that, for the most part, American schools are failing miserably. Boredom and apathy pervade classrooms, a curriculum of control predominates, and a mental health perspective and presence is lacking. How can boredom, apathy, narrow goals, underutilized resources (e.g., physical education facilities), and alienation be replaced with productivity, the development of competence, and a sense of purpose? Are "schools of joy" (Newman, 1992) a myth or possible reality? Twenty-five years since inception, many of the principles espoused by Hobbs have been clinically and empirically validated. Others will require further development and systematic assessment. Nonetheless, these principles and Re-ED programs are worthy of careful consideration as schools are restructured, programs reassembled, and missions reexamined.

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Interagency Community-Based Services for Children and Youth with Emotional and Behavioral Disabilities

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ABSTRACT

Children and youth with serious emotional or behavioral disabilities present complex problems for service delivery agencies in their home communities. The absence of coordinated interagency planning and service delivery have left many gaps in the continuum of available local services, which often has led to inappropriate and unnecessary placement in residential psychiatric programs. This article examines the current state-of-the-art regarding interagency services for emotionally or behaviorally disabled children and their families, as well as observations based on the authors' experience with a model program in Kentucky.

State child protective services removed Josh from his home when he was 5 years old due to abuse and neglect. Because he was difficult to manage, he had to be placed in a series of foster homes over the years. In the second grade, he was identified as needing special education for emotional and behavioral problems. At the age of 12, he was arrested for burglary and subsequently was incarcerated. While in detention, Josh attempted suicide and was placed in the juvenile psychiatric unit. He was diagnosed as depressed, unsocialized aggressive, and conduct disorder. Josh was placed on psychoactive medication, enrolled in biweekly group psychotherapy, and returned to the detention center. After 6 months, he was discharged into the custody of a new foster family. Back in the community, Josh continued to exhibit problems including sexually inappropriate behavior with both older and younger boys, truancy, school failure, fighting, stealing, and defiance of authority. At age 14, he stole a car and was placed in a juvenile correctional facility where he currently lives and attends school.

Like Josh, many children with emotional and behavioral disabilities (EBD) require ongoing treatment from multiple agencies. Children with emotional and behavioral problems may receive services from a series of agencies depending upon the crisis of the moment, or from a multitude of agencies simultaneously. Before reaching adulthood, Josh had been in contact with child protective services, the foster care system, and the court system; had received counseling and special education services; and had been hospitalized and incarcerated. Given the extent of services provided to Josh and children like him, one would expect a good prognosis for improvement in behavioral and emotional functioning. Unfortunately, the prognosis for children like Josh generally is poor.

Why is the treatment of childhood emotional and behavioral disorders frequently bound to fail? Many authorities in human service professions (e.g., Forness, 1989; Knitzer, 1982; Stroul & Friedman, 1986) attribute the lack of treatment efficacy to inadequate or poorly integrated services in local communities. Traditionally, treatment of children with serious emotional and behavioral problems has been fragmented and delivered in isolated artificial settings such as psychiatric hospitals and residential treatment programs where systematic programming for the generalization and maintenance of the improvements made in adaptive behavior are not addressed. Consequently, treatment gains often dissipate once the child with EBD is returned to her/his home community.

Interagency community-based treatment provides an alternative to the traditional approach to service delivery. In this article, the authors provide an overview of an interagency community-based model of services for children and youth with EBD. We present a rationale for this model, discuss implementation and outcomes, and examine future directions for professionals who treat childhood emotional and behavioral disorders.

Rationale

According to recent statistics, our nation's children and youth are in trouble. Of the poor in this country, 40% are children. Families with children are the fastest growing segment of the homeless population with children comprising 25% of this population. Of the children in this country, 25% currently live in single parent homes; and by age of 18, over 50% of our youngsters experience living in a single parent household (National Association of State Directors of Special Education, 1991).

The incidence of drug, alcohol, and child abuse in families has increased exponentially. At least 375,000 newborns are estimated to be affected by their mothers' drug abuse. Another 50,000 are born with alcohol-related problems (National Association of State Directors of Special Education, 1991). Drug use among children has increased — approximately 20% of youth between ages 12 and 17 claim to have used illicit drugs (Research Triangle Institute, 1991). Violence in our schools is another sign of the times; 16% of public school teachers have been threatened by a student while 7% have been physically attacked (U. S. Department of Education, Office of Educational Research and Improvement, 1992).

The inadequacy of our response to these youth in crisis is aptly demonstrated by outcome statistics indicating that, as a population, emotionally or behaviorally disabled youth are largely underserved, experience school failure, and do not make adequate adjustments to adulthood. Specifically, less than 1% of children who exhibit emotional/behavioral difficulties are identified and served in special education programs. Over 60% of students who are identified and served as emotionally or behaviorally disabled eventually drop out of school (U. S. Department of Education, 1991). Nearly one-third of these students are neither working nor receiving vocational training after leaving school (Neel, Meadows, Levine, & Edgar, 1988). Over a third of all emotionally or behaviorally disabled students are likely to acquire a criminal record after leaving school.

Available literature suggests that 70 to 80% of the children in this country do not receive adequate mental health services (Office of Technology Assessment, 1986). The lack of effective community-based services, as well as funding policies that favor psychiatric hospitalization (Institute of Medicine, 1989), have promoted over-reliance on these "deep end" programs (Behar, 1990). Behar estimates that over 50% of emotionally or behaviorally disabled children are placed in psychiatric facilities because their home communities do not have adequate services. Consequently, the use of psychiatric hospitalization as a primary treatment approach is increasing at an alarming rate. Weithorn (1988) observed a 400% increase in psychiatric hospitalization from 1980 to 1986.

Aside from the overuse of deep end services, other problems are associated with hospitalization as a predominant treatment approach. First, psychiatric hospitalization is prohibitively expensive. At the national level, one billion dollars are spent annually for the hospitalization and residential treatment of children with EBD (Yellon, 1991). A national survey of 37 states revealed that over 4,000 emotionally or behaviorally disabled youth were treated in out-of-state facilities at a cost of \$204,000,000 — an average of \$50,000 per youth — per year (VanDenBerg, 1989). Second, in many cases, the geographic distance between the psychiatric hospital and local community makes it difficult to monitor the child's progress and to coordinate treatment with the child's home and school. Third, because treatment takes place in an artificial isolated setting, the generalization and maintenance of treatment gains are not promoted (VanDenBerg, 1989). Fourth, the effectiveness of hospital-based psychiatric treatment has been questioned. It has been suggested that cure rates may be more a function of the severity of the child's disability than of the treatment itself (Office of Technology Assessment, 1986).

In communities where treatment is available, agencies most often operate independently, resulting in fragmented, uncoordinated services for clients. An interagency community-based service delivery model, in which services provided by local agencies and professionals are integrated to meet individual child and family needs, offers an alternative to the current state of affairs.

Interagency Model

Five types of public agencies have legal responsibility for providing services to children: education, child welfare, mental health, public health, and juvenile justice. Collaboration among these agencies has been the exception rather than the rule. In 1976, Hobbs observed that the assemblage of agencies responsible for children was in "unconscionable disarray," and 15 years later, England and Cole (1992) pointed out that this condition has not changed. Differences in definitions of client populations, eligibility criteria, and treatment philosophies are exacerbated by the lack of communication and coordination among agencies who are involved with the same child and family. Furthermore, it is the responsibility of the client to seek out the service rather than the service coming to the client (Edgar, Webb, & Maddox, 1987).

In contrast to more traditional approaches to services, an interagency community-based model provides services that are driven by individual child and family needs and that are coordinated among treatment agents. The core of this model is a transdisciplinary committee of professionals who work as a team with the family and the child to provide intensive individualized treatment within the context of their homes, schools, and communities. Major assumptions and characteristics of the model are presented in the following sections.

Assumptions. Three major assumptions characterize the interagency community-based service delivery model. First, it is assumed that treatment for emotional and behavioral disorders is more effective when it is coordinated and provided in the natural setting of the child's home, school, and community. Social service agencies traditionally have removed children from their home in order to provide treatment. Removing children from their natural surroundings and providing treatment in an artificial environment such as a psychiatric hospital usually does not lead to the generalization and maintenance of treatment gains once children are returned to their natural environments (VanDenBerg, 1989).

Fortunately, recent legislation has provided impetus for treating children's emotional and behavioral disorders in natural settings. Specifically, the 1980 Child Welfare Act established a federal priority for programs to strengthen and support natural families in caring for their children as an alternative to out-of-home placements. Also, the Education of the Handicapped Act Amendments of 1986 (Public Law 99-457) mandates treatment to preschool-aged children with disabilities and to their families in the form of an Individualized Family Service Plan. This legislation emphasizes treating children with disabilities within the family unit rather than applying treatment to children in isolation. This law also establishes transition as a priority area for children with disabilities. Attempts to implement systematic transition plans have increased the need for interagency communication and collaboration (Edgar et al., 1987).

Title V of PL 99-660 (entitled State Comprehensive Mental Health Service Plans) directs planners and policy makers toward community-based interagency services for individuals affected by mental illness. Although this bill originally focused on adults, its most recent amendments (PL 101-639) mandate state plans for children with serious emotional disturbance (Nelson & Pearson, 1991). The Children's and Communities' Mental Health Systems Improvement Act (PL 102-321) allocates \$4.9 million to facilitate the development of state interagency plans to serve children and youth with EBD. At this writing, a request for proposals has not been issued but it is likely that two to four projects will be funded (P. Andis, personal communication, January 1993; S. Forness, personal communication, January 1993).

The second assumption of the model is that intensive treatment can be delivered to the child across home, school, and community environments. Structured treatment can be provided in natural settings through a highly individualized and complex package of services that are "wrapped around" the child and family. Wrap-around services may include in- and after-school support, in-home respite for parents, transportation, crisis intervention, and skill development for parents and children. The type and extent of wrap-around services are individualized to meet the specific needs of the child and family. Also, these services are brought to the client rather than being located outside the natural setting.

The third assumption is that service delivery must be organized to respond consistently to the changing needs of the child and family. In other words, service providers must have the freedom to respond immediately to the family's needs. Flexibility in responding to individual needs is central to successful case management. Therefore, each treatment team must have the authority to make treatment decisions without going through numerous bureaucratic channels.

Characteristics. A primary characteristic of the interagency model is that treatment is delivered in natural settings. The goal is to broaden and strengthen the community as the treatment arena. In order to provide treatment in natural settings, the child and family require access to the support and training provided through wrap-around services mentioned previously. Flexible wrap-around services traditionally have not been provided by social service agencies, and therefore, the funds and staff to provide these services must be generated. In Kentucky, funding for wrap-around services have been supported by Medicaid as specified in a memorandum of agreement with the Department of Medicaid Services.

The hub of effective interagency service is a well-defined treatment team which provides intensive case management for the child and family over the long term (England & Cole, 1992). Most often, children with emotional and behavioral problems require long-term support in order to make significant improvement. The treatment team which provides these long-term services is composed of professionals and paraprofessionals who represent the agencies responsible for serving the child and family. Collaboration among agency personnel who make up the treatment teams is governed by a formal interagency agreement.

The interagency agreement addresses issues relevant to the provision of services including confidentiality, responsibility for the costs for services, due process procedures, information management, and treatment options. Ideally, memoranda of agreement should originate from the level of state government and should serve as a model for regional and local memoranda. Agreements that include shared or pooled funding are especially powerful (England & Cole, 1992). The agencies included in the contract, as well as the terms of the agreement regulating their collaboration, should vary according to local needs and service delivery patterns.

Although interagency community-based programs are characterized by great diversity, England and Cole (1992) observed that the programs have several features in common. These include an interagency steering committee that sets policy and provides overall supervision, long-term case management, and a set of core service components. Core service components consist of clinical teams that provide case management, procedures for responding to emergency situations, interventions that are provided in the home, and a range of innovative strategies to finance needed services. The defining features of this service delivery model are the communication and coordination among the providers to ensure that the client's needs are met efficiently.

Implementation

Implementing a system of interagency community-based services encompasses a number of issues including funding, goal setting, and identifying a target population to serve. The authors will draw upon the interagency model currently used in Kentucky to illustrate how some of these issues may be addressed.

Initiation. The scope of the interagency project to a large extent determines how it is initiated. Kentucky's program began with a legislative Health and Welfare Committee study. This study led to the development of a state-wide plan and legislation that mandated state and regional interagency councils, and a pool of funds totaling \$19.5 million. At the same time, a regional project was developed and matching funds were procured through a grant from the Robert Wood Johnson Foundation. The resulting project, Bluegrass IMPACT (Interagency Mobilization for Progress in Adolescent and Children's Treatment), currently serves children and families in a 17 county area. Also, the IMPACT project serves as a model to test the feasibility of arrangements and services for the rest of

the state (Phillips, Nelson, & McLaughlin, in press). Other projects also have originated with a state plan (e.g., Alaska, North Carolina, South Carolina, Vermont). Still others have originated at the local level (e.g., Norfolk, Virginia, Portland, Oregon, Ventura County, California). In general, interagency community-based programs may be initiated by any public service agency that serves children and youth with EBD.

Funding. Funding for Kentucky's interagency program (Kentucky IMPACT) was obtained through grants and by pooling funds that previously were available to agencies. For the past 10 years, the Child and Adolescent Services Program (CAASP) of the National Institute of Mental Health has been assisting states by awarding grants to facilitate the development of state and local interagency services. A CAASP grant provided funds for planning Kentucky's systems change. The Robert Wood Johnson Foundation also funded a demonstration program entitled the Mental Health Services Program for Youth. This program, now in its second year, has provided grants of \$20.4 million to partially support a wide range of projects in California, North Carolina, Ohio, Oregon, Pennsylvania, Vermont, Wisconsin and Kentucky (England & Cole, 1992).

Kentucky's interagency services also are partially supported by Medicaid funds designated for emotionally disturbed children. A regulation that permits Medicaid billing for outpatient mental health services has facilitated the use of these dollars for a range of community services. Additional funds have come from the region's mental health board and from school districts. As mentioned previously, funds from these sources are pooled to support flexible community-based responses to individual child and family needs.

Goals. Another task is establishing specific goals for the interagency program. Kentucky's program targeted three primary goals: (a) to enable children with emotional and behavioral disorders to maintain a good quality of life in their home communities, (b) to develop the community base as an arena for services, and (c) to reduce the use of expensive and unnecessary deep end services such as inpatient psychiatric treatment (Kentucky Cabinet for Human Resources, 1990). Avoidance of unnecessary psychiatric hospitalization and out-of-state placement, and the provision of care in local communities are goals common to the majority of interagency projects (e.g., Behar, 1990; VanDenBerg, 1989).

Target Population. Defining the target population serves three primary purposes: (a) developing eligibility criteria for identifying clients most in need of services, (b) determining who will provide these services, and (c) assigning responsibility for the costs of services (Epstein, Quinn, Nelson, Polsgrove, & Cumblad, in press). Kentucky IMPACT targets children who have a psychiatric diagnosis, those who require multiple services in order to make significant improvement, children who currently are receiving treatment in hospital or residential programs, and children who are at-risk for out-of-home placements.

Program Development. Program development begins with a needs assessment conducted in the locality to be served. Information from the needs assessment is used in defining the target population and in identifying the types of services to be provided (Stroul & Friedman, 1986). A system of care commonly draws upon the following sources of child and family services:

- Mental health services
- Social services
- Educational services
- Health services
- Vocational services
- Recreational services
- Operational services

In the process of conducting an assessment of the service needs of children and families, staffing requirements should become apparent. In some cases, partial interagency project staffing may be accomplished through the use of existing personnel. However, it is also likely that new staff will need to be hired and trained in order to fill existing gaps in service delivery. For example, in Kentucky, local resource coordinators were employed in each of the state's mental health regions. These professional staff members are responsi-

ble for coordinating the case review process, facilitating and evaluating referrals for review, and assigning cases to service coordinators. In addition, local resource coordinators supervise service coordinators, make recommendations concerning the use of funds for wrap-around services, provide input to the Medicaid review team, and monitor the status of children from the region being served in psychiatric hospitals and residential treatment facilities. Service coordinators in each region are responsible for helping children and families gain access to needed social, medical, educational, vocational, residential, and other services (Philips et al., in press).

A final step in the program development process is to encourage the effective use of available personnel. In order to do this, the interagency program must be publicized and other agencies must be recruited as collaborative service providers.

Space limitations do not permit the authors to provide detailed information regarding program development. However, it is important to note that implementing an interagency program is a formidable task. Numerous issues regarding training, interagency working relationships, and agency "turf" emerge. Nevertheless, the expense and equivocal success of more traditional approaches to treating children with EBD should provide some impetus for changing service delivery patterns. Also, a number of specific benefits are associated with an interagency community-based approach to the treatment of emotionally or behaviorally disabled children and youth.

Benefits

It has been suggested that an interagency community-based model will prove less costly than treatment delivered in hospital and residential treatment settings (Behar, 1990). Behar notes that the yearly cost of serving approximately 1,200 children in community-based services in North Carolina is \$30 million, or \$25,000 annually for each child. Compared with VanDenBerg's (1989) data on the costs of out-of-state care (\$50,000 per year for each child), this represents a substantial savings. The annual costs of such deep end services as psychiatric hospitalization are likely to be much higher (Epstein et al., in press).

A related benefit of interagency community-based services is the development of a continuum of services that more closely matches the range of child and family needs. Behar (1990) points out that the current model of service delivery provides such outpatient services as crisis intervention, family treatment, and individual treatment. However, very little is offered between outpatient services and residential treatment or hospitalization. A continuum of community-based services would fill the gaps with such midrange services as therapeutic camping, evening treatment programs, and a range of day and residential treatment programs. In the long run, whether community-based services turn out to be less expensive than residential treatment remains to be seen. As Edgar (personal communication, July 1991) observes, community-based services may, in fact, be more expensive but they probably are better for children and their families.

In addition, the interagency model promotes greater family involvement in the treatment process. Family involvement is more likely to promote lasting change in the home environment, and subsequently, in the child's future behavior and emotional functioning. A corollary benefit of greater family involvement is less disruption to the child and family. Moreover, when treatment is provided within the community, fewer transitions are required (Friedman, 1985).

Another outcome is greater community involvement. Community awareness of the mental health needs of children and families may lead to more support and advocacy for improved services. Community involvement also promotes the generalization of treatment gains because local professionals and family members are aware of and working toward shared goals. Related benefits include better use of community resources, the generation of local funding, better community acceptance and planning, and an increased likelihood that services will meet individual community needs (Friedman, 1985). Finally, a very important outcome — noted by Friedman and corroborated by public school teachers involved in the Kentucky program — is a reduction in child abuse and neglect in the

home. This is linked to frequent monitoring and home visits by program staff. The availability of parent training also teaches adult family members more appropriate responses to children's behavioral problems. In addition, ongoing family support and respite for adult family members probably diffuses some of the anger and frustration that is associated with the day-to-day management of children with EBD.

CONCLUSIONS

Community-based interagency planning and service delivery is a complex endeavor that involves new skills for many agency staff. However, projects around the country are demonstrating that integrated service delivery can be implemented at the local, regional, and state levels. Beginning with Stroul and Friedman's (1986) seminal work on building a system of care, a literature on strategies for accomplishing systems change and implementing interagency programs has begun to appear (e.g., Epstein et al., in press; Nelson & Pearson, 1991). Furthermore, projects have begun to publish their methods and results (e.g., Burchard, Schaefer, Harrington, Rogers, Welkowitz, & Tighe, 1991; Jordan & Hernandez, 1990; Phillips et al., in press; VanDenBerg, 1989), forming a platform on which future projects can build.

At this writing, however, little data regarding both the process of interagency community-based programing and its outcomes are available. Because the model currently lacks a sufficient database to support its efficacy, its accountability, at this point, has not been demonstrated (Nelson & Pearson, 1991). Interagency projects must employ systematic data collection procedures and implement sound experimental designs that demonstrate the efficacy, long-term effects, and ultimate cost of the model. In addition, such research should identify variables associated with successful community-based intervention. Formative evaluation procedures also should be included in evaluation designs. These should address both child progress and consumer satisfaction. Data derived from formative evaluation should be used to modify treatment plans, service delivery mechanisms, client goals and objectives, and intervention procedures (Nelson & Pearson, 1991).

Additionally, professional training must be aligned with a collaborative approach to treatment. University level training for counselors, school psychologists, social workers, and teachers often stresses an "isolationistic" approach to treatment. The isolation of academic disciplines is maintained by separate literature, curricula, professional certification criteria, and so on. The absence of integrated preservice training shifts responsibility for training professionals to work collaboratively across disciplines to inservice staff development. The recent research priorities for children and youth with serious emotional disturbance published by the Office of Special Education Programs address the development and evaluation of innovative inservice training models that include an interagency focus.

Another approach that facilitates professional collaboration is a cross-disciplinary case analysis and problem-solving session in a "grand rounds" format, used in Kentucky's Bluegrass IMPACT Program. These grand rounds are a vehicle for professionals and students in training to come together and practice transdisciplinary interactions. In the grand rounds session, the parent or guardian of the child being served presents a case history. Then an expert panel makes comments and suggestions regarding treatment. The panel is comprised of individuals from various professions including psychiatry, family therapy, social work, and education. Audience participation also is solicited. Although based on the medical model, the grand rounds format may serve as a model for trainers of professions who work with children with emotional and behavioral disabilities and their families.

The authors urge that professionals who are embarking on interagency community-based service delivery for the first time focus their planning on child and family needs. These needs supply the direction that services must take. Services must follow needs, and funds must follow children and their families. This focus gives significantly greater autonomy to interagency case managers, and therefore, systems must be developed to ensure fiscal and client accountability including staff training and constructive supervision (Nelson & Pearson, 1991).

Finally, we urge that the development of successful interagency community-based programs for children with emotional or behavioral disabilities and their families not be regarded as an end point. Ultimately, the success of such programs depends upon the existence of services that meet the needs of all children and all families in a given community, county, or state (Nelson & Pearson, 1991). Achieving a transition from human services that are haphazard, piecemeal, and often competitive to services that are integrated requires firm dedication to the concept that programs must fit the needs of people, and further, that in attempting to meet their needs, parents, professionals, and children must work as a well-coordinated team.

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Designing a Comprehensive System of Services for Indiana: Project CONNECT, Phase I

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ABSTRACT

This article provides a preliminary report on the first phase of a project to improve comprehensive services to students with emotional and behavioral disorders. Project CONNECT is a joint effort involving the Indiana State Department of Education, two lead school districts, and a university-based team collaborating to restructure state and local services. Included in the discussion are (a) guiding principles and working assumptions used to frame planning efforts, (b) a description of the operating mechanism, (c) a summary of major system change activities, and (d) results of state and local needs analysis and planning events. Themes emerging from the needs analysis are being used to develop a series of self-study modules which LEAs could use to direct their program development activities. This report is offered as an approach that might be adopted by SEAs and LEAs considering a services restructuring effort.

Two important challenges that relate to the education of students with emotional and behavioral disorders (EBD) concern the development of effective interventions, and identifying strategies that will enable such students to be placed in less restrictive environments (Braaten, Kauffman, Braaten, Polsgrove, & Nelson, 1988; Peacock Hill Working Group, 1991; Walker & Bullis, 1991). These concerns are fundamentally related in that the development of effective interventions is critical to the successful placement of children in normal educational settings. A large body of research indicates that effective educational and behavioral interventions have been available for children with EBD for over two decades (Hewett, 1968; Nelson & Polsgrove, 1984; Peacock Hill Working Group, 1991; Polsgrove, 1979; Polsgrove & Nelson, 1982; Skiba, & Casey, 1985). Yet national studies suggest that effective strategies are not being widely implemented and school programs for these students rarely include full service delivery options (Grosenick, George, & George, 1987; Grosenick & Huntze, 1983).

Further, available evidence indicates that the current quality and level of local school and community services for children with EBD and their families are failing to meet their needs. Indices such as employment status and incarceration rates show that youth with EBD have great difficulty making the transition from school to adulthood (Edgar, 1990). In a landmark document, Stroul and Friedman (1986) offered a model for a system of care that envisioned the coordination of a variety of community mental health services for children and their families. Recent analyses of transdisciplinary ventures (Nelson & Pearson, 1991) suggest, however, that this model remains more a vision than a reality.

These observations suggest that perhaps the most crucial challenge currently facing researchers and practitioners concerned with the welfare of students with EBD involves weaving effective strategies into a successful comprehensive program of services spanning schools and community agencies (LaCour, 1982; Nelson & Pearson, 1991). An ideal program would promote interagency cooperation to prevent children from "falling through the cracks" of traditional compartmentalized service systems and to reduce costs and duplication of services associated with these. It would increase the involvement of parents in school programs for students with EBD. It would offer a continuum of services that min-

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imizes long-term placement and ensures movement of children toward less restrictive alternatives. Finally, an ideal services program would capitalize on proven instructional, social, and behavioral strategies that facilitate children's learning, self-control, and adaptation to natural environments (Burchard & Clarke, 1990; Duchnowski & Friedman, 1990).

This article chronicles activities involved in the planning and development phase of Project CONNECT. This project is focusing on improving services in Indiana for children who have emotional and behavioral disorders by addressing the issues identified previously. The project is a joint venture of the Indiana State Department of Education, Division of Special Education (INDOE/SPED), Indiana University, and two local educational agencies (LEAs) supported by state and federal grants.

The general plan for the project involves two phases. The focus of Phase I is on: (a) continued development of a foundation for improving services at the state level, (b) cultivating a climate for change at both state and local levels, (c) collecting information for restructuring state and local services, (d) generating a state working plan for guiding change efforts, (e) designing model district programs, and (f) developing a series of self-study modules for use by districts across the state for restructuring local services. Thus, the project represents an attempt to modify variables at both state and local levels to improve the quality of services for children with EBD and their families. The two participating school districts are serving as lead districts in developing blueprints, procedures, and products that may be used by other districts to guide their restructuring efforts.

Phase II of the project involves implementing model district programs generated in the planning phase, field testing the self-study modules, and evaluating the impact of these efforts on local service systems, service providers, and children with EBD.

This report describes the process followed in implementing the above goals and presents the preliminary Phase I results. This article is intended to share our procedures and experiences and thereby stimulate a dialogue among project directors, program administrators, and other professionals faced with the complex task of restructuring services for children and youth with emotional and behavioral disorders.

Guiding Principles

Underlying many efforts for restructuring services for children with EBD is the need to provide more appropriate, effective, and less expensive services (Behar, 1990; VanDenBerg, 1989). As problems with these children mount and funding dwindles, service providers are forced to try to do more with fewer resources. This typically translates into reorganization efforts which consolidate and coordinate functions of various agencies and the pooling of finances and other resources (Stroul & Friedman, 1986).

The barriers to developing viable interagency collaborations have been well documented in the literature (Duchnowski & Friedman, 1990; LaCour, 1982). Unfortunately, failures have been far more frequent than have successes (Byles, 1985; Weiss, 1981). Some of the factors cited include (a) lack of a shared philosophy and treatment approaches across professional lines, (b) conflict regarding handling and confidentiality of records, (c) separate budgets, (d) interagency rivalry, (e) poor planning, and (f) personnel attrition (Nelson & Pearson, 1991).

By all accounts, any systems change effort represents a considerably arduous and trying process. Therefore, we have found it necessary to adopt some guiding principles gleaned from the literature and adopted from our collective experiences to help weather this process. The following ideas have been helpful in maintaining perspective on our efforts.

- Systems change proceeds at a glacially slow pace; it is a frustrating and often unrewarding process. Weiss (1981) indicated that the path to developing coordinated human services is strewn with failed projects.
- Creating a *climate for change* may be the most important goal in the process of systems change (Harvey, 1990). This involves making participants aware of various approaches that have worked in other states, enlisting contributions from various sources, and providing key persons with information regarding progress. Hershberger

(1981) has indicated that the process of interagency change may indeed be as important as the product in terms of laying a foundation for future efforts.

- Systems change is perhaps best conceptualized as a simultaneous *bottom-up* plus *top-down* strategy which enlists a cross-section of individuals representing various factions affected by it (Stroul & Friedman, 1986).
- Key "stakeholders" should be involved at every phase of the change process and should have an opportunity to contribute to the development of plans and strategies even if they are not major contributors in the process (Nelson & Pearson, 1991).
- Systems change typically is erratic and unpredictable, and too much organization of efforts may be as detrimental to the process as too little. Thus, it may be most productive for individuals involved in a change process first to develop a broad vision of ideal goals and then to organize local groups to translate this plan into action (Pava, 1986). This approach also might facilitate the "small wins" that build momentum for further change.
- Planners should continuously be attentive to, and attempt to capitalize on, serendipitous events as these arise. Reorganizations of agencies, legislative initiatives, rules revisions, and changes in funding patterns and agency personnel all represent such opportunities. Phillips, Nelson, and McLaughlin (in press) noted that a series of events — including a Kentucky SEA study on the status of services to children with disabilities, a plea to the legislature for action from the Kentucky state mental health service agency, and hiring of personnel with vision and collaboration — were all serendipitous events that led to the realization of Kentucky's IMPACT plan for system change.

Working Assumptions

Risk factors that predict serious emotional or behavioral disorders in children continue to grow in our society. For a climate of interagency collaboration to exist, there must be an awareness and understanding that the scope of the problem is beyond the capacity of any one agency to solve. As Stroul and Friedman (1986) observe, "The conclusions of nearly all commissions and experts converge in recommending a multiagency, multidisciplinary system of services for emotionally disturbed children and their families" (p. v). Based on the literature and our own and others' experiences in restructuring services, the authors identified five assumptions that guide our efforts.

1. *New programs cannot be created.* In this era of budgetary restraint, we can no longer rely on the creation of new programs and services to meet the needs of students with EBD. Stroul and Friedman's (1986) comprehensive system-of-care model describes an ideal array of services for an effective system. We have recognized, however, that where components of this model are absent, they will have to be synthesized from existing services through creative interagency cooperation.

2. *Services must be child-focused.* Young (1990) suggested that existing agency services tend to be eligibility-focused rather than child-focused, that is, services typically focus on determining a child's eligibility for existing programs rather than identifying services to address the specific needs of the child. Recent alternative model programs, such as the Alaska Youth Initiative and Project Wraparound (Burchard & Clarke, 1990), attempt to fit program components and services to the identified needs of children and their families.

3. *Services should be community-based.* Despite a general movement of the field of special education toward inclusion of students in the educational mainstream, available data indicate that students with emotional and behavioral disorders are significantly over-represented in the most restrictive elements in the continuum, particularly in residential care (Kauffman & Lloyd, 1992). Services in the most restrictive settings remove children from natural environments and appropriate social models. In addition, they are simply not cost-effective. Epstein et al. (in press) observe that costs for out-of-state placements of children with EBD may run as high as \$90,000 or more per year. Thus, the concept of least restrictive environment must be extended beyond the school setting to include the local community; that is, a greater number of treatment options must be made available within the community to meet the needs of this population. A creative approach must be taken to design or modify existing local services to meet these needs more flexibly.

4. *A continuum of services is necessary.* With appropriate applications of existing instructional and behavior management technology, it is clear that more children with EBD could be served successfully in the educational mainstream than are now (Knitzer, Steinberg, & Fleisch, 1990; Peacock Hill Working Group, 1991). Given the magnitude and tenacity of the problems presented by many of these children, however, it seems probable that, even in the best programs, some proportion of students labeled EBD will continue to need services in highly structured settings. A major problem with placement of children labeled EBD in restrictive settings, however, is that most tend to remain in these placements (Knitzer, Steinberg, & Fleisch, 1990). The authors believe that placement in a structured setting should not be an irrevocable condition. Currently, much of the focus of assessment and decision making is on the transition from general education to special education services — the eligibility decision-making process. In order to decrease the possibility of more restrictive options becoming long-term placements for students with EBD, greater attention must be paid to assessment and planning for transition back to less restrictive environments (Fuchs, Fuchs, Fernstrom, & Hohn, 1991; Hoier, McConnell, & Pallay, 1987). Appropriate planning, personnel training, and services must be available to ensure a successful transition to less restrictive settings.

5. *Long-term goals should be emphasized.* Available information suggests that current programs for children with EBD often focus more on meeting the needs of the system rather than those of the child; that is, placements are frequently determined as a means of removing a difficult child from the educational mainstream as a solution rather than attempting to address a youngster's needs. Knitzer and colleagues (1990) indicated that most programs tend to focus on making the children conform to often arbitrary rules rather than attempting to provide critical academic and social behaviors. We believe that programing for students with EBD must somehow transcend such short-term objectives and move toward teaching these children skills that will enable them to become more adaptive and independent in natural environments.

Operating Mechanism

In addition to our guiding principles, we recognize that to be even partially successful in this enterprise requires the close cooperation of a cadre of individuals with similar experience and perspective. The working mechanism of Project CONNECT therefore revolves around the coordinated efforts of three project teams: a university-based team, a State Division of Special Education team, and an LEA team. Although each of the project teams have different responsibilities, they meet regularly to share progress and plan strategies. In addition, state and local advisory committees have proven invaluable in guiding systems change efforts.

University team. The university team has primarily responsibility for providing access to the research literature and for providing technical assistance to the other project teams. This group has identified promising models and practices in the literature, conducted state and local needs analyses, facilitated the formation of state and local advisory and leadership committees, helped to create a statewide climate for change, and is in the process of developing a series of self-study modules on topics identified as areas of need from state and local needs analyses.

INDOE/SPED team. The Indiana Department of Education/Division of Special Education (INDOE/SPED) team, comprised of personnel from that agency, mainly focuses its efforts on developing the foundation for statewide change, orchestrating new local services options, and providing funds for innovative program development. In relation to Project CONNECT, the INDOE/SPED has hosted working conferences for developing a "State Working Plan" that will ultimately be used as a resource for local districts to guide their efforts at program renovation. In addition to project-related activities, this team has been active in a variety of other service improvement activities at the state level which impact local services.

LEA team. The LEA team consists of key administrative and related services personnel representing the two participating local districts. This team, along with their respective

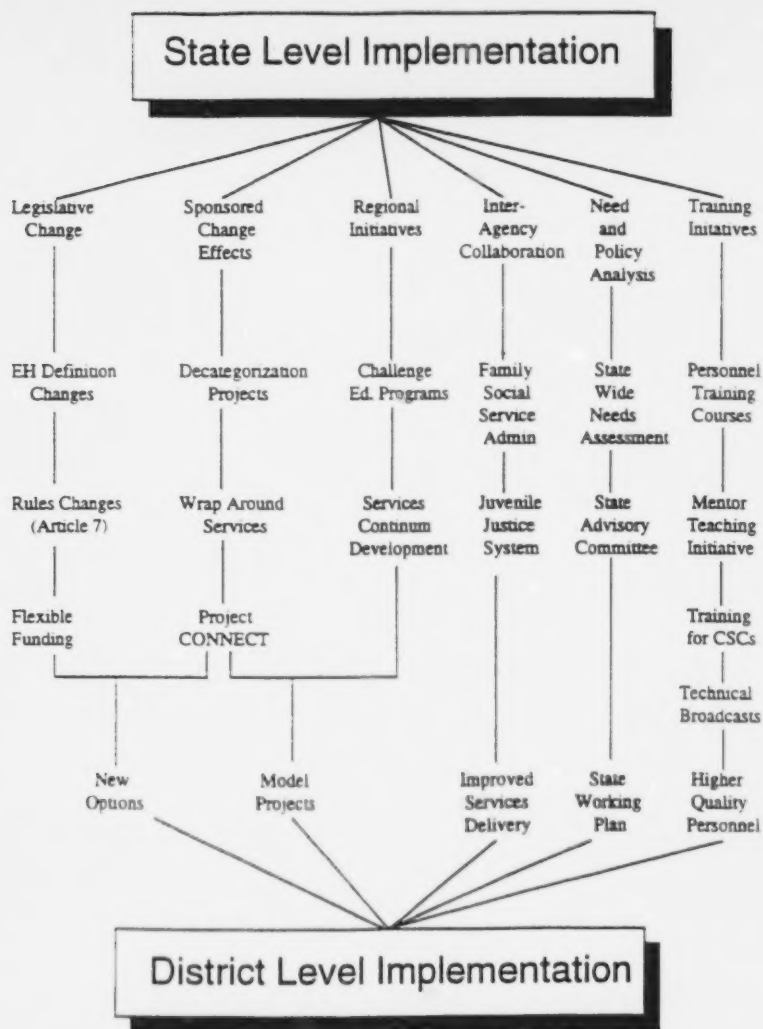


Figure 1. Schematic representing change efforts at the state level and their interrelations.

leadership and interagency committees, is primarily responsible for identifying local district needs and for implementing plans for developing a comprehensive array of services. The LEA team initiated efforts to forge working agreements with local agencies and cooperated with the university team in conducting local needs analyses and in developing local blueprints for restructuring services.

Advisory committees. In addition to the project teams, the expertise of a state advisory committee and LEA leadership teams have been indispensable as mechanisms for facilitating change. These groups have proven helpful in interpreting information from various sources, generating plans for restructuring services, serving as sounding boards for evaluating project activities and products, and suggesting new directions for action.

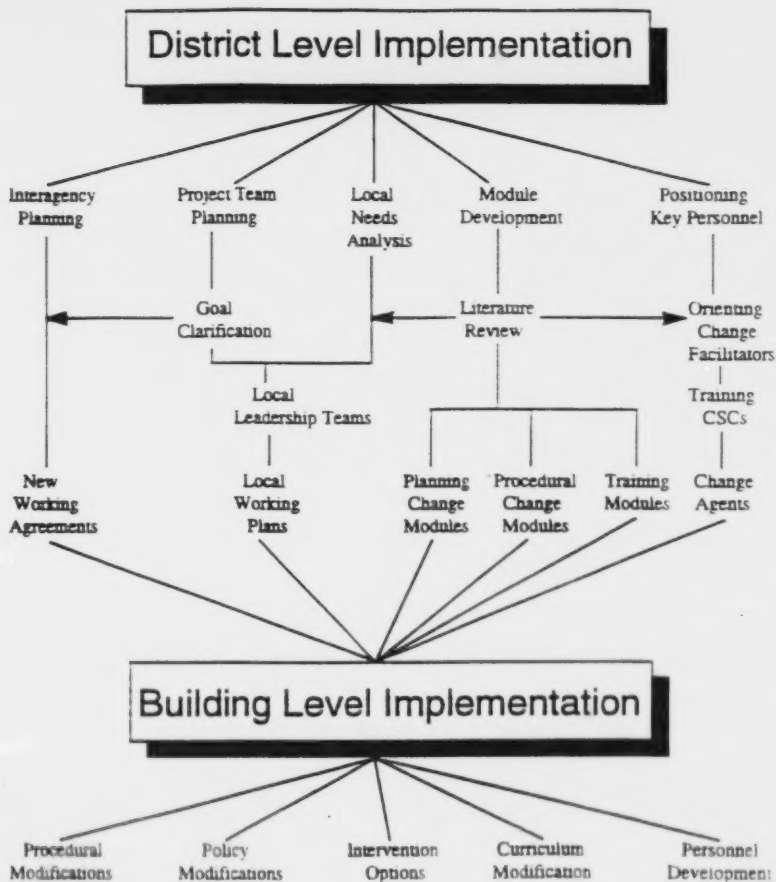


Figure 2. Change efforts at the district and building level and their interrelation.

LEVELS OF IMPLEMENTATION

Although the responsibilities of the project teams are clear, the actual activities are interwoven. The complexities of the project, therefore, probably are best understood as a three-tiered framework involving state-level, district-level, and building-level implementation; implementation of state-level activities affect district-level activities which, in turn, eventually influence service providers at the building level. As the first phase of the project has focused on state and district planning, results of these activities are reported.

The project teams have invested a considerable amount of effort in cultivating a climate for change and planning for change at various levels. This has generated considerable interest and involvement of key stakeholders and produced a high level of enthusiasm for implementing plans developed in Phase I. Figures 1 and 2 illustrate the various project activities at state and district levels and their actual or potential influence on increasingly local services.

State-Level Implementation

The INDOE/SPED team in particular has been actively engaged in laying a sound foundation on which to base the current project. These efforts revolve around five activities: (a) changing operating policies and rules, (b) launching regional program development initiatives, (c) developing interagency collaborations, (d) conducting state needs analyses, and (e) sponsoring personnel development efforts (see Figure 1).

Legislative change. A major shift in the approach used to providing services for children with multiple needs occurred in 1990 when the INDOE/SPED initiated a systems change movement through their development of a multidimensional model of services. The Indiana Challenge of Change: Developing Services for Multi-Needs Students model is based on the tenet that services for these children must be based on the individual needs of the student. Moreover, service delivery should be viewed as a cross-disciplinary responsibility requiring the commitment and participation of representatives of all agencies touching children. The plan calls for promoting changes at several levels: legislative change efforts, sponsored change efforts, regional initiatives, statewide planning initiative, interagency collaboration, and special training projects (see Figure 1).

Legislative policies and rules changes. In the state of Indiana the term *emotional handicap* is used in state regulations to refer to students with emotional and behavioral disorders. One of the critical recent legislative policies changes has been to alter the state definition pertaining to students with EBD by removing the questionable qualifiers *seriously* and *socially maladjusted*. These changes, made in response to best professional opinion and research evidence (Council for Children with Behavioral Disorders, 1990), will hopefully remove some of the confusion and controversy surrounding those exclusions.

In addition, new state rules (*Title 511, Indiana State Board of Education Article 7, Rules 3-13*, 1992) have paved the way for school corporations to explore innovative programs. For example, allowing a regular educator to serve as the "teacher of record" while requiring qualified special educators in classrooms with students with disabilities has facilitated collaborative teaching arrangements in the educational mainstream. The creation of a flexible funding formula also has availed new options and possibilities for restructuring special education programs.

Sponsored change efforts. The state also has sponsored several change efforts in a bid to create new options and facilitate the development of new programs. Legislative efforts during the 1992 session allowed three districts across the state to waive any state or local rule or requirement, on a case-by-case basis, that interferes with the overall goal of providing coordinated services to families. This will enable those districts to remove barriers to decategorizing the resources provided for child welfare, probation, foster care, education, and mental health while addressing the comprehensive needs of children.

Regional initiatives. Over the past year, several projects have been initiated by the INDOE/SPED to improve regional services across the state. In an effort to assist local communities in moving toward the goal of community-based wraparound services, federal discretionary dollars are being accessed to provide seven regional positions known as Child Service Coordinators. The role of the Child Service Coordinator is multifaceted and includes the following functions:

- Identify existing services, resources, and programs
- Identify service gaps within a local community or region
- Identify barriers to child service delivery
- Serve as a resource to decision making groups (e.g., case conference committees, Local Coordinating Committees, child service planning teams)
- Provide technical assistance to local school corporations regarding alternative wraparound or residential services
- Serve as a liaison to child serving agencies.

The first task identified for the Child Service Coordinators will be to target students currently placed out of Indiana through alternative/residential service dollars. Wherever possible, the coordinators will work to return these students to their home community through alternative service plans that emphasize coordinated, wraparound service delivery.

Interagency collaboration. A major reorganization of social services for the state of Indiana occurred over the last year with the consolidation of the Department of Human Services, Vocational Rehabilitation, Welfare, and Mental Health into the Family Social Services Administration (FSSA). This consolidation provides an opportunity to link our goals with those of the FSSA, and INDOE/SPED personnel have held a series of planning meetings to identify ways in which the two agencies can collaborate for improving services. A collaborative relationship has also been established with the Indiana Juvenile Justice System, specifically in addressing issues of special education in facilities operated by Juvenile Justice and the Department of Corrections. The current focus of those efforts is the formulation of appropriate special education standards and procedures.

Finally, a new flexible funding formula should facilitate the development of interagency efforts. The Department of Education worked with the state legislature to change a 1979 policy requiring that funds for students with disabilities so severe that schools could not provide services be used only for placement in residential schools. New legislation changed this budget item to allow these funds to purchase individual services in the community. This program has created dramatic changes in service in its first 2 years of operation. In 1990, fully 80% of the students in this program were placed in out-of-state residential placements; currently, only 35% of these students are placed out-of-state, and almost one-quarter are being served under the new community wraparound option.

State needs analysis. A statewide needs analysis was conducted as part of the planning process related to the project. Responses to a questionnaire were received from 41 district special education program directors and teachers of students with emotional and behavioral disorders. This questionnaire asked them to identify the type of local services being offered, potential problems in providing services to children with EBD, and their evaluation of the effectiveness of current services. Results of this survey were provided to a State Advisory Committee commissioned for the Project. These data served as a stimulus for the committee to develop a State Working Plan. The plan, which is in the final draft stage, provides a comprehensive mission statement, vision, and a series of objectives with accompanying suggestions for reaching these. The final version of the Plan will be incorporated into a self-study module that will provide a template for local districts for restructuring services.

Training initiatives. In addition to the above activities, various training initiatives have been sponsored by the INDOE/SPED last year to address shortages and inadequacies of teachers of children with emotional and behavioral disorders. A teacher mentoring program has also been established which pairs teachers on emergency licenses with veteran special educators. This change provides support for new teachers entering the field.

District-Level Implementation

Simultaneous with the above state-level activities, considerable planning and change efforts have occurred at the district level. These have been driven primarily by collaboration between the university and LEA teams. The major activities related to planning district-level implementation include: (a) conducting meetings with various agency representatives to map collaborative working agreements for improving services, (b) establishing local leadership teams to develop plans for restructuring district services, (c) conducting local needs analyses for participating LEAs, (d) developing self-study modules based on an analysis of local needs, and (e) reassigning key personnel to new positions designed to facilitate and institutionalize change.

Interagency planning. Burchard and Clarke (1990) have noted that a shared philosophy is essential if interagency collaboration is to be effective. Both districts have worked to establish a shared understandings and goals over the course of Phase I of the project. In Hancock/South Madison, 45 representatives of a variety of agencies participated in writing a state grant petitioning the state to allow a waiver of regulations that might impede interagency cooperation. These representatives included school superintendents, directors of mental health centers, representatives of welfare and probation, and at-risk counselors, teachers, and program coordinators from the public schools. In the Indi-

anapolis Public Schools, members of both public and private community agencies have been key members of the Leadership Team that has planned the activities for Phase II of this project. In addition, the project has facilitated regular interagency conference meetings in each district and developed prototypic cooperative agreements. As a result of these efforts, both participating districts also have clearly articulated local working plans and emerging interagency cooperative arrangements.

Establishing local leadership teams. To meet project objectives related to planning for restructuring services at the local level, a two-pronged strategy is being used. First, we have established local leadership teams in the two districts comprised of key administrators, teachers, related services personnel, and parents; these teams have received results of the needs analysis from their district and technical assistance to aid in planning changes. These resources facilitated the development of a set of strategies to address the most pressing problems with regard to services for children with EBD identified in each district.

LEA needs analysis. Consistent with a strategy of planned change, an analysis of needs for service improvement was conducted in both participating districts. The needs analysis consisted of responses to a questionnaire on local services from 346 regular teachers, building administrators, teachers and parents of children with EBD, and related services personnel. Also conducted were 46 individual and focus group interviews. These data were then analyzed, summarized, and presented to local leadership teams in each district for planning purposes.

The results from local needs analyses were very consistent with those obtained from the state study. Six themes emerging from these data sets have provided a focus for developing local plans for restructuring: identification and eligibility issues, developing a services continuum, discipline/behavior management issues, expanding the curriculum, revamping community services, and enhancing parental involvement.

Self-study module development. A unique aspect of Project CONNECT is the development of self-study modules. The primary purpose of these is to provide a mechanism for institutionalizing both the process of change and the adoption of new strategies for providing services for children with emotional handicaps.

The modules correspond to the six identified themes that emerged from the state and local needs analyses. As currently planned, these products will consist of a hard copy manual presenting critical information from research on effective practices, readings, bibliography, exercises, activities, model forms, and suggested media resources. It is anticipated that these modules will be extremely useful in the hands of administrators in planning change efforts and for staff charged with providing personnel development activities. Once completed, they will be distributed by the INDOE/SPED to districts that express interest in wanting to initiate a local restructuring effort. Currently under development are (a) planning for change modules (Overview and Conducting a Needs Analysis); (b) procedural change modules (Building Interagency Collaboration, Assessment and Continuum of Services, Increasing Parental Involvement); and (c) training modules (Behavior Management, Curriculum).

Positioning Key Personnel

As the project moves from the planning to implementation phase of systems change, we hope to extend the present knowledge base in this area by evaluating both the impact of the broader model and a limited number of interrelated components. Of equal importance is our goal to institutionalize a model that has an empirical and philosophical base that can be replicated in a variety of communities. To accomplish these objectives, we have identified several "components" of effective systems change efforts and matched them with the categories of needs generated from our state and local needs analysis and planning. Two important components are the Family Services Coordinator and the Systems Change Facilitator. In both districts, these positions are being filled by already available personnel, such as behavioral consultants or school psychologists being released for special assignment.

Child services coordinator, local level. There is evidence that for interagency service delivery to be effective, a case management/coordinator position is critical (Burns & Friedman, 1990; Lingo & Henry, 1990; Martin et al., 1983; Weiss, 1981). Thus, the participating districts will initiate new positions this coming year that will function as local equivalents of the regional child service coordinators described previously. This individual will coordinate school and community services for children and their families. The local child service coordinator (CSC) will function as a critical link in assuring that children with EBD receive the services they need and that services are changed as the needs of children and their families change. The involvement of the CSC increases the probability that the various systems in a community are responsive to the individuals they were designed to serve (Stroul & Friedman, 1986).

The child service coordinator position is similar to the therapeutic case advocate position first identified by Knitzer (1982), who recommended "a spokesperson to help work with various agencies and get needed services delivered in an appropriate, coordinated, and sensitive fashion." Young (1990) expanded on Knitzer's conception of the therapeutic case advocate by emphasizing a therapeutic case advocacy model that fosters an "individualized system of care surrounding each child and family." It is important to underscore the strong advocacy component at the core of the CSC model. Both case advocacy and this model are case-centered. By definition, case-centered implies that the needs of the child and her/his family become the focus of decision making and service coordination, an important philosophical and attitudinal change.

Systems change facilitator. A component of an ideal systems change model that emerged from the Phase 1 planning process was the need for an individual who could orchestrate and coordinate broad-based change activities in the existing services system. The role of the change facilitator has been identified in systems change literature in connection with the Concerns-Based Adoption Model (CBAM) described by Hall and Hord (1987). Essentially, this individual — for a brief or extended period of time — may function as a consultant in facilitating change efforts.

Specifically, the systems change facilitator will be involved in (a) training building-based personnel in procedures for managing inappropriate behavior and teaching social skills; (b) supporting the development of "peripheral intervention teams" (Graden, Casey, & Christianson, 1985); (c) assisting related services personnel in revamping assessment procedures; (d) facilitating building-based planning teams; (e) organizing and supporting the local Family Services Coordinating Councils; (f) developing various interagency agreements for service linkages, cost sharing, and joint ventures (Nelson & Pearson, 1991); (g) locating sources of funding for creating service options; (h) providing assistance in training related services personnel in collaborative case management and family support planning; (i) developing project monitoring procedures; and (j) orchestrating the application of self-study modules developed for the project.

SUMMARY AND FUTURE DIRECTIONS

While the first phase of Project CONNECT was intended solely as a planning phase, it has accomplished much more than merely a passive planning function. We are beginning to see signs that the planning process is moving toward the implementation phase: planning groups have stated their need to begin the change process proper, working arrangements and regularly scheduled meetings involving agency personnel are providing momentum to improve and expand service options; and the needs analysis process has alerted stakeholders and created a broad climate for change. Most importantly, there is a positively charged atmosphere and a shared belief that our efforts will produce results.

Much remains to be undertaken in the implementation phase of Project CONNECT. The planning process revealed a need to make major modifications in the service delivery model in order to move to a more dynamic and effective system. Perhaps the main concept that emerged is the identification of a strong need for creating a permanent role in the current services system for a Child Services Coordinator. We envision the CSC as a problem solver, child advocate, case manager/services coordinator, and intervention agent.

Yet merely creating another role will not necessarily improve local services. This person should also function as a catalyst to strengthen the functions of existing service mechanisms such as local services coordinating committees. We envision the CSCs as working with these groups to develop, implement, and monitor Individual Family Services Plans for children who are at-risk for residential placement or who may be returning to community-based services options. We anticipate that establishing critical case functions related to the CSCs and institutionalizing a related set of procedures and evaluation strategies will permanently alter services and will make them more responsive, efficient, and cost-effective for students with emotional and behavioral disorders.

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Stress Among General and Special Education Teachers of Students with Emotional or Behavioral Disorders: Possible Implications for Full Inclusion

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ABSTRACT

This study examines the sources and effects of stress reported by 424 teachers working with emotionally or behaviorally disordered students in Los Angeles and San Bernardino, California. It also examines effective and noneffective coping strategies as reported by these teachers. These results have serious implications for the preparation and retention of teachers of students with emotional or behavioral disorders. These findings are also significant in that teacher stress needs to be considered when planning for the full integration of these students into general education classrooms as advocated by the regular education initiative. General education, special education, and bilingual teachers completed the Pullis Inventory of Teacher Stress which identifies the sources and effects of stress as well as coping strategies that help teachers manage stress. The stress factors include pupil factors, building factors, career factors, and workload factors. This study focuses on those factors that pose the greatest threat to integrating emotionally or behaviorally disordered students into general education classrooms.

It can be argued that the two most important problems facing the field of behavioral disorders today are the shortage of special education teachers with expertise in emotional or behavioral disorders (EBD) and the full inclusion of these students in general education classrooms. Both of these issues affect the quality and quantity of educational programming for students diagnosed as EBD.

The shortage of fully qualified teachers for students with EBD is well documented (Akin, 1989; Bowen, 1988; Grosenick & Huntze, 1981; Lawrenson & McKinnon, 1982). Nationally, the teacher shortage in special education is reaching epidemic proportions (Carraker, 1989). Systematic examinations of the shortage of special education teachers have identified three areas impacting the crisis: recruitment, induction, and retention (Absalam & Hafner, 1990; American Association of Colleges of Teacher Education, 1988; The Council for Exceptional Children, 1989). Of these areas, the retention of fully trained special education teachers is perhaps the most significant.

Several authors (Keavney & Sinclair, 1978; Lipsky, 1980; Maslach, 1982; Mazur & Lynch, 1989; Pullis, 1992; Sweeney & McCabe, 1992; Weiskopf, 1980) have suggested that occupational stress contributes greatly to burnout, absenteeism, and ultimately attrition among teachers. These studies suggest that several factors need to be considered when examining the increased attrition rate among special education teachers. Previous research in the areas of teacher burnout and related stressors has consistently identified similar categories of stress.

The categories of stress most often cited in prior studies cluster into the four factors derived from the Pullis Inventory of Teacher Stress (PITS; Pullis, 1983, 1992): (a) building/support stressors, (b) career stressors, (c) job-related/workload stressors, and (d) pupil related stressors (Cunningham, 1983; Pullis, 1983). Building/support stressors include lack of participation in the decision-making process, lack of resources, and attitudes and/or behaviors of principals or coworkers. Career stressors include inadequate salary, lack of career opportunities, and lack of job status. Workload stressors include demands on time, amount of work required, class size, and paperwork. Pupil stressors refer to attitudes toward students, discipline problems, threat of violence, and lack of motivation. Iwanicki (1983) suggested that a fifth factor, cumulative or total stress, should be

included in future studies of teacher stress. Therefore, the sources and effects of stress on attrition of teachers working with students with EBD will be examined here.

The second area to be examined is the impact of stress on general education teachers as they integrate students with EBD into their classrooms. Many states have embraced the Regular Education Initiative (REI; Stainback & Stainback, 1984; Will, 1986) as an effective way to serve students with special needs in a cost effective manner. The full inclusion of all special education students, including those with EBD, in general education classes has raised many questions among general education teachers and administrators. The questions most frequently voiced are (a) "Are general education teachers trained to teach students with special needs?" (Kearney & Durand, 1992) and (b) "What level of support will be available to general education teachers as they attempt to accommodate special needs students into their classrooms?" (Fuchs, Fuchs, & Bahr, 1990; Stainback & Stainback, 1990; York, Vandercook, McDonald, Heise-Neff, & Caughey, 1992). Included in the concerns over level of support are the attitudes of general education staff and administrators toward students with special needs. Specifically focusing on administrators, researchers have asked, "What is the knowledge and awareness level of special education laws and teaching strategies among general education teachers and administrators?" (Bowen, 1989; Valesky & Hirth, 1992).

It has been demonstrated that how well special needs students do in the mainstream is directly related to general education teacher attitude, skill level, and support (Brophy, 1979; Cooper & Speece, 1990). Kaufman, Kameenui, Birman, and Danielson (1990) have suggested that special education, by its self-imposed isolation and costly bureaucratic structures, may have lost the opportunity to be a guiding force for general education. They suggest that many of the techniques developed for educating special needs students would also be effective in general education settings. These skills are essential for all teachers if students with special needs are to be fully included in general education. However, by failing to include general education teachers in special education staff development programs to share these new techniques of instruction and behavior management, special education may have missed its best chance to impact general education. Another view would hold that many strategies used in special education were borrowed from general education but are no longer being used in general education. This is particularly true of general education teachers who began their teaching careers after the passage of Public Law 94-142 in 1975, and therefore did not have to modify their teaching techniques to accommodate students with disabilities.

Supporters of the REI and full inclusion contend that, by failing to demonstrate how special education can be incorporated into general education classes, special education has forfeited the right to determine how special education services will be delivered (Semmel, Abernathy, Butera, & Lesar, 1991). This creates a situation in which some of our most difficult to manage students are now being placed in classes where the teachers and buildings receiving them are minimally prepared to provide for their needs and maximize their success. Thus, the stress level of general education teachers likely to receive students with EBD will also be examined to identify issues that will need to be addressed to help ensure the success of EBD students placed in their classes.

METHODOLOGY

Respondents

Copies of the PITS were distributed to general, special, and bilingual education teachers in Los Angeles and San Bernardino Counties during the 1989-1990 school year; 600 questionnaires were distributed and 424 usable questionnaires were returned for a response rate of 71%. Also, 13 other questionnaires were returned without key teacher demographic data necessary for analysis. Questionnaires were distributed to special education teachers during regularly scheduled staff meetings. The sample of special education teachers includes resources specialists and teachers of self-contained special day classes (SDCs) from segregated special education centers and from mainstreamed settings. Questionnaires were distributed to general and bilingual education teachers

enrolled in a university special education mainstreaming course required by the State of California to obtain a clear general education teaching credential. Teachers in these courses included preservice teachers, teachers in their first 5 years of teaching, and returning experienced teachers who needed the mainstreaming course to be approved for new single or multiple subjects credentials. In addition, questionnaires were completed by teachers from a model demonstration school in each county. Given the "captured" nature of this sample, results of this study should be viewed with caution.

Instrumentation

The PITS contains questions that measure teacher stress across four factors described by Pullis (1992): pupil stressors, workload stressors, career stressors, and building stressors. For this study, a total stress score was computed by averaging the previous four factor scores. The PITS also contains questions that identify the effects of stress on teachers and coping skills that teachers have found helpful in reducing stress. Two of the questions that identify the effects of stress — How often do you feel like quitting teaching? and How often do you feel unsuccessful as a teacher? — were selected to serve as dependent variables for this study. Instructions provided with the PITS requested that respondents answer the questions in reference to their own experiences teaching students with EBD.

The resulting sample contained 211 general education teachers, 183 special education teachers, and 30 bilingual teachers. The majority of the sample (52.12%) teach at the elementary level. Teacher assignment by type of district shows 54.72% teach in urban school districts, 35.38% teach in suburban school districts, and 9.91% teach in rural school districts. Other sample demographics are detailed in Table 1.

TABLE 1
Sample Demographics Given in Percentage (N = 424)

Gender	Male	20.05
	Female	79.95
Race	Native American	0.94
	Black	4.01
	Hispanic	6.37
	Anglo	83.73
	Other	4.95
Level	Preschool	6.37
	Elementary	52.12
	Middle/junior high	19.10
	Senior high school	21.23
	Adult/other	1.18

Analysis

The 424 usable questionnaires were coded, the five stress factors were computed, and the resulting data were entered into a database for statistical analysis. Items relating to each of the four primary stress factors are listed in Table 2.

RESULTS AND DISCUSSION

The Sources of Stress

Teachers completing the PITS indicated that teacher workload stressors were associated with the highest amount of stress. This finding is consistent with the findings of Pullis (1992) and Sweeney and McCabe (1992). Workload stressors were followed by pupil stressors, total stressors, building stressors, and career stressors, respectively. Mean scores and standard deviations for each factor are found in Table 3. Scores on all five fac-

tors indicate that teachers are experiencing at least moderate levels of stress from each factor. Moderate levels of stress on one or more factors can contribute to poor job performance, lack of satisfaction in teaching, burnout, and ultimately leaving the field (Sweeney & McCabe, 1992). A score of 1.0 indicates not at all stressful, 3.0 indicates moderately stressful, and 5.0 indicates extremely stressful.

TABLE 2
Makeup of PITS Stress Factors

Factor 1 - Pupil Stressors	
1. Loud, noisy	
2. Impolite or rude	
3. Poorly motivated	
4. Dealing with parents	
5. Defiance of authority	
6. Threat of aggression/physical harm	
7. Lack of appreciation from students	
Factor 2 - Workload Stressors	
1. Not enough time to do assigned work	
2. IEP meetings	
3. Too much work	
4. Responsibility for student progress	
5. Students evaluations/paperwork	
6. Monitoring behavior	
7. Demands on after-school time	
8. Number of students/class size	
Factor 3 - Career Stressors	
1. Poor career opportunities	
2. Inadequate salary	
3. Low status	
4. Inability to meet personal/professional goals	
5. Lack of fun/enjoyment in teaching	
Factor 4 - Building Stressors	
1. Inadequate discipline policy	
2. Attitude and behavior of principal	
3. Lack of recognition of teaching	
4. Inadequate equipment/materials	
5. Lack of consultation and assistance	
6. Attitude and behavior of other teachers	
7. Having to discipline students	
8. Lack of participation in decision making	
9. Evaluation by principal/supervisors	

(Pullis, 1983, 1992)

TABLE 3
Rank Order of Teacher Stress Factors (N = 424)

Factor	Mean	Standard Deviation
Workload stressors	2.832	0.791
Pupil stressors	2.764	0.796
Total stressors	2.742	0.926
Building stressors	2.662	0.838
Career stressors	2.604	0.947

TABLE 4

Rank Order and Level of Stress Factor by Teacher Assignment (N = 424)

	General Education <i>n</i> = 211	Special Education <i>n</i> = 183	Bilingual Education <i>n</i> = 30
Workload	3.004	2.595	3.070*
Pupil	2.942*	2.544	2.854
Total	2.935*	2.504	2.841
Building	2.842*	2.451	2.804
Career	2.760*	2.417	2.640

*denotes highest level reported for that factor

When considered by teacher assignment to general education, special education, or bilingual education settings, the rank order of the factors did not vary by assignment (see Table 4). However, each group reported different levels of stress for each factor. Sweeney and McCabe (1992) found statistically significant differences on each stress factor when controlled for teacher assignment.

Table 5 shows the rank order of stress factors by class assignment. With the single exception of workload, general education teachers reported the highest level of stress on each of the stress factors. Bilingual teachers reported the highest amount of stress from workload stressors. Special education teachers in self-contained special day classes (SDCs) reported the lowest levels of stress on each of the five factors. Consistent with Pullis (1983), the resource teachers reported higher levels of stress than other special education teachers.

TABLE 5

Rank Order of Stress Factors by Class Assignment (N = 424)

Pupil	Workload	Career	Building	Total
General	Bilingual	General	General	General
Bilingual	General	Resource	Bilingual	Bilingual
Resource	Resource	Bilingual	Resource	Resource
SDC	SDC	SDC	SDC	SDC

The relative stress levels of teachers by class assignment is important as it has been shown that excessive stress can impair a teacher's ability to optimize learning in the classroom. This finding suggests that general education teachers are already experiencing the greatest levels of stress reported and are therefore the least likely to be able to handle the additional stress associated with accommodating students with EBD in their classes.

It is also important to note that the resource teachers who are expected to ease and support the transition of students with EBD into the mainstream are experiencing higher levels of stress than special education teachers in self-contained classrooms. This finding suggests that the resource teachers' abilities to function as the primary support person for the general education teachers in the full inclusion model may be suspect. Therefore, it is reasonable to question the quality of service that will be provided to students with EBD if they are fully integrated into the mainstream.

Stress was also examined by grade level. Table 6 shows that teachers working with adult learners reported the highest levels of stress on all five factors. However, this finding may not be typical of all teachers in adult education. All the adult teachers in this sample worked at the same site where they shared space with a high school. The added stress of not having their own classrooms may have contributed to the inflated scores reported by the teachers working in adult education settings.

TABLE 6
Rank Order of Stress Factor by Grade Level (N = 424)

Pupil	Workload	Career	Building	Total
Adult	Adult	Adult	Adult	Adult
Junior High	Elementary	Junior High	Elementary	Junior High
Elementary	Junior High	Elementary	Junior High	Elementary
High School	Preschool	High School	High School	High School
Preschool	High School	Preschool	Preschool	Preschool

Among K-12 teachers, elementary teachers reported the highest levels of workload and building stressors. Junior high teachers reported the highest levels of stress on the pupil, career, and total stress factors. High school teachers reported the lowest levels of stress on the workload factor. Preschool teachers reported the lowest levels of stress on the other four factors.

The elementary teachers indicated that class size and student diversity contributed the most stress to the workload factor. Lack of resources and administrative support contributed the most stress to the building stress factor. This suggests that general education teachers at the elementary level may need to have smaller class size and more support within the building before they would be willing or able to take on the additional challenges of having students with EBD placed in their classes.

Teachers at the junior high level reported that defiance of authority and threat of aggression or physical harm contributed the most stress to the pupil stress factor. Because teachers at the junior high level also reported the greatest amounts of total stress and career stress, it seems unlikely that they will be willing voluntarily to take on the additional challenges posed by students with EBD. Therefore, it appears that the existing stress levels of teachers included in this sample present serious obstacles to the full inclusion of students with EBD in general education classrooms at the elementary and junior high level.

The Effects of Stress

The five most frequently reported effects of stress are:

- feeling exhausted
- feeling frustrated
- feeling overwhelmed
- stress carry-over
- feeling guilty

It is important to note that all of these effects of stress are also symptoms of clinical depression (American Psychiatric Association, 1987). Like depression, they also tend to be progressive if left untreated. Stress carryover is especially important. When teachers displace their frustrations from work onto their families, their family lives as well as their professional lives can become problematic. This results in increased stress, overall life dissatisfaction, and depression. Any or all of these contribute to ineffective teaching and/or teacher attrition.

Effective Coping Strategies

The five most effective coping strategies reported by survey respondents included:

- organizing time/setting priorities
- doing relaxing activities
- diet/exercise
- discussing problems with professional colleagues
- taking a day off

Each respondent was asked to indicate if s/he had ever used a given coping strategy. If a given strategy had been used, s/he was asked to rate how effective it had been found.

in reducing stress. The strategies reported above received the highest effectiveness ratings from teachers completing the PITS.

These strategies were recognized as effective coping skills even by those teachers who reported they were unable to use them consistently themselves. For instance, several teachers reported that they knew they needed to get organized and set priorities, yet they reported they were too *stressed out* to do it. Other teachers reported they were so stressed out they couldn't remember any relaxing activities, let alone find time to do them. Diet and exercise were also problematic for many teachers who reported they were unable to work either into their schedule. Unfortunately, diet and exercise go together. If one fails to maintain a healthy diet, it becomes harder to exercise (Sweeney & McCabe, 1992).

"Discussing problems with professional colleagues" can be helpful provided the colleagues are both professional and less stressed than you. Special education teachers working on general education campuses reported that this strategy did not work for them. These teachers felt isolated, as often there were only one or two other special education teachers at their site. In most cases, they reported that their general education colleagues did not understand what they did and were therefore unable to assist them in problem solving.

"Taking a day off," while often needed, was not viewed as effective by many teachers. The problem with taking a day off was that when they returned to school their stress level usually increased as they felt guilty over being gone and had to deal with whatever went wrong while they were away.

All of these strategies appear to work better when they are used proactively. Once a teacher becomes stressed out, it is difficult to harness enough energy to actually do the activities that can be effective in relieving stress. In fact, knowing what they *should* do can actually increase the stress level for many teachers.

Problem Coping Strategies

Problem coping strategies were identified as those that were tried by teachers but were reportedly not very effective. In some cases, these coping skills are harmful to teachers and students. The five most frequently reported problem coping skills included:

- eating
- drinking coffee
- drugs/alcohol
- professional counseling
- smoking cigarettes

Over 60% of all respondents reported eating to help relieve stress. This may explain why only 23% of all respondents found diet and exercise effective in stress reduction. Nearly 50% of those responding reported drinking coffee to relieve stress. The caffeine no doubt helps to combat the exhaustion; however, the side effects of excess caffeine may be worse than those of stress. This goes along with the finding that 46.7% of all respondents reported using drugs or alcohol to relieve stress. This suggests that teaching is a high risk occupation and that teachers may be in danger of becoming alcohol and/or substance abusers.

Of the respondents, 41% reported that they had tried professional counseling but did not find it very effective. Responses to open-ended questions suggested that counseling was effective in relieving stress for those teachers who could afford it. However, many teachers were reluctant to turn in claims on their mental health benefits for fear they would be fired for being unstable. Other teachers reported that they had benefited from counseling until their insurance benefits ran out but then they were unable to continue paying privately.

This finding is troubling as it suggests that teachers are unwilling to take advantage of a health benefit to which they are entitled for fear they may lose their job if the personnel office discovers they are seeking help. Given the earlier finding that 46.7% of the teachers responding had tried drugs or alcohol to relieve their stress, it also seems unlikely that

those who become substance or alcohol abusers will seek help voluntarily. Thus, their job performance will suffer and they may ultimately be forced out of teaching for not taking advantage of resources available to keep them on the job.

Finally, 38% of teachers responding reported that they smoked to relieve stress. Smoking may actually be stress producing for those teachers who attempt to smoke on smoke-free campuses or reside in smoke-free communities.

CONCLUSIONS

This study has demonstrated that teacher respondents across all settings and grade levels are experiencing at least moderate levels of work-related stress on all factors measured by the PITS. The highest levels of stress were reported by bilingual and general education teachers. In all cases, analysis of variance revealed the levels of stress reported by special education teachers were significantly less ($p < .05$) than those reported by their general education counterparts. Some possible explanations for this finding is that special education teachers generally have smaller classes, have more homogeneous students, and have specific skills necessary to work with the kinds of challenges they find in their students. General education teachers typically identified large class size, diversity of student population, and workload as their greatest sources of stress. These same issues were not viewed as stress producing among special education teachers in SDCs. However, special education resource teachers agreed with their general education colleagues and cited large caseloads and diversity of students served as their greatest stress producers.

Among special education teachers, resource teachers reported the highest levels of stress. They were followed by special education teachers working in general education settings and special education teachers working at segregated special education sites, respectively. This suggests that the full inclusion of students with EBD into general education classes may increase the levels of stress among general education teachers to a point where they might consider leaving teaching. This is especially true at the elementary and junior high school levels where general education teachers reported the highest levels of existing stress.

Further, this study suggests that the cumulative effects of stress contribute to job dissatisfaction, and in extreme cases, may lead to clinical depression in many teachers. Attempts to cope with stress are often counterproductive, and in some cases (such as alcohol or drug use), may further contribute to ineffective teaching and/or teacher attrition. Therefore, it is safe to conclude that the full inclusion of students with emotional or behavioral disorders in general education settings will require that many issues related to stress be addressed prior to implementation. These include:

- preservice and inservice training on stress management
- assessment of existing stress levels in general education settings prior to placement of students with EBD
- work/case loads of resource teachers will need to be carefully monitored to prevent burnout
- general education teachers may require more than one course in behavior management and special education best practices prior to including students with EBD in their classes
- optimal placement for some students with EBD may continue to be a self-contained classroom where teachers are under less stress and therefore better able to deal effectively with the needs and behaviors of students.

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Collaboration: Self-Perceived Knowledge, Skills, and Activities of Rural Special Educators of Students with Behavioral Disorders

Regina M. Foley, Nancy A. Mundschenk, and Sidney R. Miller

ABSTRACT

The purpose of this investigation was to ascertain three things: (a) the frequency of interactions between special educators and community agencies; (b) teachers' knowledge of the philosophy, functions, and services of various community agencies; and (c) their current level of competence in collaboration skills. Data from a survey of 30 special educators serving youth with behavioral disorders in a rural area of southern Illinois are presented and discussed. These data indicate that a majority of the respondents interacted most often with general educators, and infrequently with community service providers. Although aware of the philosophy and functions of community agencies, respondents had limited knowledge of the referral procedures and contact persons. They rated themselves relatively high on skills related to developing collegial relationships such as developing trust with others, but relatively low on skills related to collaborating with community agencies. The implications of these results are discussed in relation to both research and training.

The commitment to full inclusion and the imperative of budgetary constraints of the 90s has spurred the effort of state and federal agencies to promote and support the concept of collaboration. Depending on the literature reviewed, the process involves two or more individuals working together in a co-equal relationship with shared decision making and accountability (Cook & Friend, 1991), or an interagency process in which there is a pooling of resources to address the needs of students and the community (Guthrie & Guthrie, 1991). Whether focus is on the individuals or the agencies, the process is designed to facilitate decision making among representatives from differing agencies and professional disciplines. The collaborative movement is the latest effort on the part of government to maximize its cash and human resources in the delivery of services to disabled learners.

Although articulated for more than a decade, the collaborative process itself has been hindered for a variety of professional and territorial reasons. Among the inhibitors cited are conflicting professional role responsibilities (Aloia, 1983); interagency policy conflict, eligibility criteria, funding patterns, and inconsistent national policy implementation (Johnson, Bruininks, & Thurlow, 1987); an absence of research (West & Cannon, 1988); and the need to validate practices and outcomes (Cook & Friend, 1991).

In spite of the calls for improved collaborative service delivery, there continues to exist the perception that many adult providers and agency representatives remain reluctant to share knowledge and territory when the collaborator is perceived as a competitor for scarce resources (Evans, 1991). Evans further reported that professional providers generally prefer to work alone. This wastes human resources and contributes to the professional disenchantment among other colleagues with shared interests and goals.

Particularly critical was the Johnson, Pugach, and Hammittee (1988) finding that professional personnel lack a mutual knowledge base for collaboration. Compounding the problem, Little (1982) found that, in unsuccessful endeavors, professional personnel often lack a common language base. These findings were affirmed by Glatthorn (1990).

Much of the descriptive literature seeks to explain what collaboration is and how it should be implemented in the schools and community. The recommendations include providing collaborators time to explore and address assessment and programmatic issues (Gerber, 1991), improving "transdisciplinary" training (Golightly, 1987), establishing sys-

tems approaches toward the problem-solving process (West & Idol, 1990), and improving the follow-through in program implementation aspects of the process (Guthrie & Guthrie, 1991). Lesser attention has been given to the type and the content of the training provided to personnel expected to initiate and maintain collaborative efforts, such as improved communication and problem-solving skills.

These obstacles are increased as interprofessional and interagency collaboration seeks to identify and serve not only the mildly disabled child, but as agencies seek to address the needs of more severely disabled youth within a rural community-based environment. Epstein, Quinn, and Cumblad (1992) reported that efforts in delivering community-based wrap-around programs for severe behaviorally disordered youth were experiencing uneven success in Illinois. Beyond the concept, Epstein et al. (1992) reported that agencies and universities need to refocus their policy priorities, personnel training, assessment package, program content, and cultural awareness to effectively consummate the collaboration process.

The purpose of this investigation was first to determine what rural public school personnel believe they know about the philosophy, function, referral process, and personnel of 14 state and local agencies that are frequently involved in the monitoring and delivery of services to disabled students. Second, it sought to determine school personnel's self-perception of their skill level relative to often cited competencies that are described as essential to the collaborative process. Lastly, the investigators will articulate what they believe are critical issues that must be addressed if collaboration is to work.

METHOD

Subjects

A sample of 36 rural educators serving students with behavioral disorders (BD) was selected from public school programs in a sparsely populated farming and mining area in southern Illinois. Each respondent was either a graduate or currently enrolled in the teacher training program in special education at a major university in southern Illinois. Respondents were asked to complete a survey designed to ascertain the current collaboration practices of rural special education teachers; 30 teachers (83%) agreed to participate in this investigation.

Of the 30 respondents to the survey, a majority were experienced teachers with a mean of 9.63 years teaching experience who had spent more than half of that time directly serving behaviorally disordered students ($M = 5.30$, $SD = 4.33$). Twelve (40%) of the respondents had earned a Master's degree, and the group as a whole reported receiving an average of 21.96 clock hours of collaboration training (range = 0 - 150).

All of the respondents provided educational services to students in integrated settings in community housed public schools with 43.3% (13) serving students in resource programs, and 36.7% (11) in self-contained programs. The remaining 20% (6) served students in programs with combined options (e.g., resource and self-contained). The majority of respondents (57%) reported serving students in junior or senior high school grade levels (grades 7-12), while 30% served students in elementary grade levels (K-6). One respondent reported that her program served both elementary and secondary grade level students (1-12), and 10% of the teachers surveyed provided educational services for students in the middle school grades (5-8).

Survey Instrument

The survey instrument was developed by the authors from a review of competencies identified in the literature on consultation and collaboration (e.g., Friend, 1984; Glatthorn, 1990; West & Cannon, 1988) and from a list of possible collaborators from the school, community, and home settings.

The survey instrument consisted of four sections: (a) community agencies, (b) professional interactions, (c) collaboration knowledge and skills, and (d) demographic information. Each of the four sections of the questionnaire was preceded by brief instructions on how the respondents were to complete the items. The first section, community agencies,

listed 14 agencies or services often accessed by students with behavioral disorders, their families, and teachers. These included social services (e.g., Department of Children and Family Services), crisis centers (e.g., Domestic Abuse Center), dropout prevention programs, juvenile justice programs, vocational rehabilitative services, and so forth. Respondents were asked to indicate whether or not they were knowledgeable about the philosophy, functions, referral procedures, and contact person for each agency.

The professional interactions section listed 20 groups of individuals with whom special educators serving behaviorally disordered students may engage in collaborative efforts. These groups were organized into three categories: (a) special education professionals (e.g., special education administrators, school psychologists, social workers), (b) general education professionals (e.g., teachers, counselors, paraprofessionals), and (c) community agencies (e.g., juvenile justice personnel, mental health counselors, advocates). Teachers were asked to report the average number of interactions per month for each of the groups listed as well as the most frequent reason(s) for the interaction.

The collaboration knowledge and skills section included 7 knowledge and 18 skill areas suggested as important for participation in collaborative interactions. Teachers were asked to rate their current level of competence for each item on a 5-point Likert-type scale (i.e., none to superior).

The final section of the survey, demographic information, requested information on teaching experience, current method of service delivery, grade level of the students served in their program, highest academic degree earned, and the amount of training received in collaboration skills.

Procedure

Graduates, or current teachers enrolled in a graduate teacher training program in special education at a major university in southern Illinois, were selected for inclusion in this study. Survey participants were identified and solicited using two methods. First, those teachers who were currently enrolled and serving students with behavioral disorders were requested to complete a survey. Second, other members of the class were asked to solicit the cooperation of their colleagues serving behaviorally disordered students in their respective schools in rural areas of southern Illinois. Each respondent to the survey was contacted in person or by phone and a verbal commitment to participate in this investigation was obtained. The purpose of the investigation was explained and teachers were asked to complete the survey. Completed surveys were returned by mail or hand carried by the graduate student volunteers.

Data Collection and Analysis

All questionnaires were returned within 3 weeks of the time they were disseminated. Prior to coding data for analysis, the questionnaires were checked for completeness and accuracy. The investigators had agreed in advance that questionnaires not completed or responses which violated the protocol would be eliminated; no questionnaires were eliminated. Individual responses from the questionnaires were coded by two of the investigators who worked in tandem and monitored the accuracy of the recording process. These data were analyzed using an SPSS (1988) statistical package for calculation of frequency and percentages.

RESULTS

Community Agencies

In Table 1 data are presented on the percentage of respondents knowledgeable of the philosophy, functions and services, referral processes, and contact person for 14 identified community agencies. The data reveal a pattern of perceived awareness that shows a relatively high level of knowledge of the agencies by most of the respondents, with a few exceptions. For example, more than 80% of these special educators indicated an understanding of the program philosophy for social service agencies, of GED programs, and of junior colleges; over 70% indicated the same awareness for five other agencies; and 60%

TABLE 1
Special Educators' Knowledge of Community Agencies and Their Services

Agencies	Program Philosophy		Functions Services		Referral Procedures		Contact Person	
	Yes	%	Yes	%	Yes	%	Yes	%
Social services	25	83.3	26	86.7	22	73.3	15	50.0
Crisis centers	14	46.7	16	53.3	6	20.0	3	10.0
Halfway house	21	70.0	19	63.3	12	40.0	11	36.7
Dropout prevention programs	18	60.0	13	43.3	8	26.7	7	23.3
Literacy programs	20	66.7	20	66.7	12	40.0	13	43.3
GED programs	25	83.3	24	80.0	16	53.3	18	60.0
Junior college	26	86.7	23	76.7	21	70.0	15	50.0
Technical/vocational programs	22	73.3	19	63.3	12	40.0	7	23.3
University services for disabled students	23	76.7	23	76.7	16	53.3	17	56.7
Vocational rehabilitation services	21	70.0	22	73.3	19	63.3	16	53.3
Mental health services	22	73.3	22	73.3	18	60.0	17	56.7
Substance abuse programs	20	66.7	22	73.3	15	50.0	14	46.7
Juvenile justice programs	16	53.3	16	53.3	11	36.7	11	36.7
Parent training programs	13	43.3	11	36.7	5	16.7	2	28.0
Mean		68.0		65.7		46.0		41.0

understood the mission of three more. This left just three agencies where the program philosophy was reportedly not understood by at least 60% of the respondents.

A very similar pattern is found in regard to the percentage of respondents who understood the functions and services of the agencies. When looking at referral procedures, however, the perceived awareness pattern changes, showing a decrease in the percentage of knowledgeable educators in regard to all 14 agencies, and most of the percentages decrease even further when knowledge of the contact person is considered. In fact, 50% or more of the respondents were aware of the referral procedures for only 6 of the 14 agencies, and the GED program was the only agency for which more than half of the educators (60%) reported knowing whom to contact to initiate services.

Professional Interactions

The mean estimates of the frequency of monthly interactions between special educators serving students with behavioral disorders and education and community service providers appear in Table 2. The average number of monthly interactions ranged from .17 (vocational rehabilitation specialists) to 20.21 (general education teachers). It seems that special educators of behaviorally disordered students interact the most with general educators, followed by their special education colleagues instructing students with behavioral disorders and other disabilities.

The occurrence of interactions between special educators and community service providers is relatively infrequent. For a majority of the identified community service

TABLE 2
Mean Estimates of the Frequency of Interactions per Month with Education and Community Service Providers by Special Educators of Students with Behavioral Disorders

Service Provider	M	SD
Special Education		
Administrators	9.90	8.66
Teachers of students with behavioral disorders	16.84	9.16
Teachers of students with other disabilities	18.92	11.07
Consultants	2.30	4.50
School psychologists	4.07	4.06
Related service professionals	4.80	6.14
Social workers	1.79	2.54
Transitional specialists	.72	1.79
Regular Education		
Administrators	13.14	9.09
Teachers	20.21	11.85
Counselors	9.52	7.63
Vocational educators	6.86	8.02
Paraprofessionals	13.35	12.44
Community Agencies		
Juvenile justice authorities	1.70	4.11
Social workers	1.40	3.30
Mental health counselors	1.33	3.74
Vocational rehabilitation specialists	.17	.46
Private service providers	.33	.76
Outside consultants	.24	.99
Advocates	.38	.38

TABLE 3

*Mean Ratings of the Self-Perceived Collaboration Competencies
of Special Education Teachers of Students with Behavioral Disorders*

Competency	<i>M</i>	<i>SD</i>
Identifying consultation and collaboration models	3.03	.81
Identifying the different professional perspectives of the participating individuals	3.47	.82
Identifying the types of information needed for the collaborative process	3.50	.68
Identifying situations in which potential conflicts may arise within the collaborative group	3.77	.77
Identifying factors related to the resistance of colleagues to participate fully in the decision- making process and implementation of an intervention	3.53	.86
Identifying plans to assess specific agency policies and services	3.27	.83
Identifying factors that affect the success of service coordination among community and school services	2.90	.94
Implementing strategies to assess students' needs for community agency services	2.83	.99
Developing a sequential action plan for delineating the steps, information needs, and timelines for the completion of services among agencies	2.77	1.14
Using strategies to determine the availability of community services	2.69	1.04
Entering into equal working relationships with others for planning and developing students' programs	3.69	.89
Implementing strategies to improve listening skills	3.38	.78
Defining the problem in behavioral terminology	3.90	.98
Participating in the generation of possible solutions for a specific academic or social problem	3.90	.86
Using interviewing strategies to define a specific academic/social problem	3.50	1.04
Using paraphrasing techniques to assure the other person is being correctly understood	3.80	.76
Using statements to provide, seek, and clarify information	3.63	.76
Using questions to provide, seek, and clarify information	3.66	.84
Using nonevaluative, behavior specific feedback during collaborative interactions	3.63	.89
Establishing mutual trust with other individuals	4.10	.80
Implementing strategies to resolve conflict situations in a collaborative group	3.43	.73
Implementing strategies to manage the resistance of colleagues during the collaborative process	3.33	.76
Implementing an interpersonal problem-solving process to structure collaboration activities	3.06	.79
Using direct informal measures to clarify the nature of an identified problem	3.73	.69
Using direct informal measures to monitor the effectiveness of interventions	3.60	.86

providers, the respondents indicated they interacted less than two times per month with these service providers. In particular, the number of contacts between special educators and community service providers was less than once per month for vocational rehabilitation specialists, private service providers, and advocates.

Collaboration Competencies

The respondents' self-perceived mean skill ratings for each of the 25 collaboration competencies are listed in Table 3. Generally, the respondents reported they were of average skill (range = 2.69-4.10) for a majority of the collaboration skills. They rated themselves above average for three competencies: establishing mutual trust with other individuals, defining a problem in behavioral terminology, and using interviewing strategies to define a specific academic/social problem. However, they described themselves to be of less than average skill in areas related to collaborating with community agencies. Specifically, the lowest rated skills were associated with identifying factors that affect the success of service coordination, using strategies for assessing students' needs for community services, determining the availability of community services, and developing a sequential action plan for coordinating the delivery of services by multiple agencies.

DISCUSSION

The purposes of this study were to describe the self-reported collaboration knowledge, activities, and skills of special educators serving students with behavioral disorders in a rural setting. The survey respondents were asked to indicate their knowledge of the philosophy, services and functions, referral procedures, and initial contact person of 14 identified community agencies and to describe the frequency of their interactions with general and special educators and community service providers. In addition, they were requested to rate their present skill level for 25 collaboration competencies.

The respondents indicated they were knowledgeable of the philosophy, services, and functions of the identified community agencies, while a large percentage of the respondents reported they were unaware of the referral procedures and the contact person to initiate a referral or services. The discrepancies in special educators' knowledge of community agencies and their functions suggest two possible situations. First, these individuals may have developed a very superficial knowledge base of community agency processes and efforts. It appears that school and community agency personnel jointly need to create interdisciplinary staff development programs that apprise both educational and community service providers of targeted community agencies, their functions and services, and procedures for accessing services. This mutual information base has been identified as a critical component for effective collaboration and coordination of services among community agencies (Johnson et al., 1987).

Second, special educators may not have been trained to participate in interagency collaborative activities. Previous research has indicated that most special education pre-service programs have not included interdisciplinary training as part of their programs (Courtnage & Smith-Davis, 1987; Fender & Fielder, 1990). The literature clearly indicates that preservice and inservice providers will need to examine their training agenda and broaden the scope of their programming to include interdisciplinary collaboration experiences particularly as they relate to rural communities (e.g., organizational psychology of rural communities, interdisciplinary practicum experiences, impediments to communication).

The predominance of collegial interactions between general and special education colleagues may be influenced by several factors including the shared responsibility of delivering educational services to individual students, proximity of service delivery, and a similar educational language and knowledge base. The almost daily interactions between general and special educators is most likely a function of coordinating the delivery of individual student's education programs and monitoring students' progress in mainstream classrooms. Furthermore, in rural settings only one special educator may be assigned to each school. Accordingly, the number of interactions occurring between general and spe-

cial educators may be inflated due to the unavailability of another special educator with whom to collaborate. A potential secondary benefit of the low ratio of special educators to general education teachers is that they may begin to develop a mutual language base that allows them to engage in more productive collaborative dialogue and interactions. Previous research has shown that general educators engaging in a high frequency of collegial interactions have developed a shared language (Little, 1982).

The limited number of collegial interactions with community service providers may be a reflection of several issues in the delivery of rural services observed by the investigators. The first issue is the unavailability of a comprehensive set of community services. Particularly in small communities, many mental health, vocational, and social services may be delivered by a regionally oriented agency located in another community. Therefore, the lack of collegial interactions may be an indication of the unavailability of these particular services within the community. Second, in order for agencies to work together, it is necessary that there be a willingness to collaborate and develop service agreements (Flynn & Harbin, 1987; Guthrie & Guthrie, 1991; Johnson et al., 1987). The reported infrequent contacts between special educators and community service providers may be attributed to the fact that access to such services is limited by the absence of comprehensive service agreements between the school districts and existing community agencies; or perhaps agencies are reluctant to relinquish territory to an apparent competitor for resources. Third, the sporadic interactions may suggest that special educators lack an in-depth understanding of the services and functions of community service providers. In any case, they have failed to access all of the services that facilitate their students' academic, social-emotional, and vocational skills development. Future research endeavors should certainly address educators' knowledge of community agencies, their willingness to collaborate with these agencies, and their knowledge of the agencies' functions and services.

Consistent with previous research (Foley, 1991; Friend, 1984), special educators perceive themselves to be average in the skills relating to inschool collaboration. Since many of the collaboration skills emphasize effective inschool communication and problem-solving behaviors, educators may view these inschool skills as adequate for their profession. They describe themselves as being competent because they do not view communication and problem-solving skills as dynamic, requiring evolving behavior to achieve interagency collaboration. The same respondents recognize that they have less than average skills when working with community agencies. These skills deficits may be related to several factors including their inadequate knowledge base of community agencies and their functions and services, the infrequency of their interaction with community agency service providers, and the lack of preservice and inservice training addressing interagency coordination activities.

The generalization of these findings to other special educators serving behaviorally disordered youth is limited for several reasons. First, the nonrandom sampling procedure may have resulted in a group not representative of special educators providing services to students with behavioral disorders. Second, the survey methodology is dependent upon the accuracy of the respondents in estimating their level of knowledge and skills. Factors such as the overestimation or underestimation of their knowledge and skills, as well as social desirability, may have affected the accuracy of the responses. Other methodologies such as direct observation may yield significantly different results. Third, the frequency of collaborative interactions occurring between special and regular educators as well as school personnel and community service providers may be unduly influenced by the opportunities to engage in collaborative interactions. Finally, the sample was drawn from a largely rural area of southern Illinois; therefore, these data are not descriptive of educators providing services in suburban and urban areas in this and other states. Certainly, additional research should address the knowledge and skills levels of educators in other locales throughout the state and nation.

The findings of this study have implications for both research and training. Research and training endeavors should address the depth and breadth of the knowledge levels of

educational and community service providers with regard to other targeted community agencies. Specifically, these efforts should focus on their knowledge of the philosophies and goals, functions and services, and referral procedures. Furthermore, additional research is needed to document the collaboration skills of educators and other community service providers as a guide for creating staff development programs. It also appears that preservice and inservice programs should address collaboration training skills as they relate to working with community agencies.

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